Nebraska FY 2014
Preventive Health and Health Services Block Grant

Work Plan

Original Work Plan for Fiscal Year 2014
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Executive Summary

*This **Preventive Health and Health Services Block Grant (PHHSBG)** Work Plan describes work being done during Federal Year 2014 or planned for Fiscal Year 2015. It is submitted by the Nebraska Department of Health and Human Services (NDHHS) as the designated state agency for the allocation and administration of PHHSBG funds.*
***Funding Assumptions**: Nebraska's total award for FY2014 from the Preventive Health and Health Services Block Grant is $2,536,795. This amount is based on the updated funding allocation table distributed by CDC.*

***Funding Rationale:** Since the establishment of the PHHSBG, the funds have been used to address leading causes of death and disability and of years-of-potential-life-lost. The NDHHS seeks input from the Nebraska Preventive Health Advisory Committee (NPHAC) in making decisions about utilization of funds allocated to Nebraska. Members of the NPHAC are informed of the allowed uses of PHHSBG funds, and the role of the NPHAC. They are provided with information about the results of activities carried out by funded programs, current evidence-based best practice and the availability of other public health resources. The NPHAC operates under bylaws established when the Advisory Committees became required in 1993, with periodic modifications approved by the Advisory Committee members. The members are selected because of their professional or subject area expertise and their interest in public health.*

Proposed Allocation and Funding Priorities for FY 2014
DIABETES PROGRAM

***Diabetes Deaths (HO D-3)**: $73,900 will be utilized to reduce the death rate due to diabetes through clinical interventions and increasing awareness of preventing and controlling Diabetes. The funds are awarded to the NDHHS Diabetes Prevention and Control Program. Activities include:*

- *Provision of diabetes self-care at two community-based clinics primarily serving minority and low income clients.*
- *Train leaders and provide of support for chronic disease self-help education courses.*
- *Surveillance through collection of data with the Behavioral Risk Factor Surveillance System.*

EMERGENCY MEDICAL SERVICES PROGRAM

***Rapid Pre-hospital Emergency Care (HO AHS-8):** $30,000 utilized to reduce heart disease mortality in targeted counties. The funds are awarded to the NDHHS Emergency Medical Services Program. Activities include:*

- *Design, implement or enhance a STEMI response system enabling local Emergency Medical Services (EMS) to directly route patients who are experiencing a STEMI or **ST**-segment **E**levation* **M**yocardial **I**nfarction** to a facility capable of treating this cardiac condition. A STEMI response system will need to include 12-lead electrocardiogram (ECG) in the field and transmission of ECG to a facility with definitive care available.*
- *Provide training to local ambulance services in Cardiac Emergency Awareness. Training regarding transmission of ECGs will also be provided to EMS services.*
- *Provide education to the public about cardiac events and the STEMI alert system through print media, health fairs and subject matter experts at public events.*

- *Provide opportunity for public to participate in heart health screening and follow-up consultation.*

** ST-segment elevation in an ECG waveform*
***Myocardial infarction, commonly called heart attack*

INFECTIOUS DISEASE PROGRAM

***New HIV Infection (HO HIV-2**): $54,000 utilized to increase the percentage of high-risk persons tested for HIV/AIDS. Funds are awarded to the NDHHS Infectious Disease Prevention and Care, HIV Prevention Program. Activities include:*

- *Contracting for anonymous and confidential laboratory testing on 6,000 samples at no cost to the client.*

***Chlamydia (HO STD-1**): $30,000* utilized to reduce the prevalence of Chlamydia trachomatis infection among Nebraskans age 15 to 34 years. Funds are awarded to the NDHHS Infections Disease Prevention and Care, STD Program. Activities include:*

- *Contracting for 3,500 tests for sexually transmitted diseases (STDs) at no cost to the client.*

**Chlamydia and Gonorrhea use dual collection, testing for both STDs from the same specimen.*

***Gonorrhea (HO STD-6**): $21,750* utilized to reduce the prevalence of Gonorrhea infection among Nebraskans age 15 to 34 years. Funds are awarded to the NDHHS Infectious Disease Prevention and Care, STD Program. Activities include:*

- *Contracting for 3,500 tests for sexually transmitted diseases (STDs) at no cost to the client.*

**Chlamydia and Gonorrhea use dual collection, testing for both STDs from the same specimen.*

MINORITY HEALTH PROGRAM

***Culturally Appropriate Community Health Programs (HO ECBP-11**): $77,400 utilized to identify current health disparities and health needs among racial ethnic minorities, Native Americans, refugees and immigrants, as other vulnerable, at-risk populations in Nebraska. Based on identified disparities and needs, work to equalize health outcomes and reduce health disparities through education of health care providers who serve these populations. Funds are awarded to the NDHHS Office of Health Disparities and Health Equity. Activities include:*

- *Health education sessions to raise knowledge and awareness of chronic diseases and maternal child health concerns among minority populations across Nebraska.*
- *Identify health disparities (leading cause of death, infant mortality, low birth rate) among various racial ethnic groups.*
- *Collect minority Behavioral Risk Factor data in minority populations.*
- *Update socioeconomic status, health status and minority population growth reports.*
- *Identify critical behavioral risk factors for three federally recognized Native American Tribes.*

***Local Health Personnel Continuing Education (HO PHI-2)** $25,000 invested in establishing a system of support for community health workers. Community Health Workers (CHWs) are also known as: outreach workers, promotoras, patient navigators, and lay health ambassadors by the various programs that utilize them. They come from and work in underserved communities of Nebraska and develop one-on-one relationships with the persons they serve. Funds will be awarded to local health departments, tribal health departments, and other non-profit local health agencies which compete successfully for the subgrants. The project will:*

- *Inventory the existing training programs, agencies that employ them.*

- *Conduct a survey to determine the number of CHWs working in Nebraska.*
- *Identify essential curriculum component to establish standardized training.*
- *Identify key roles and responsibilities to establish standard scope of services.*
- *Assure core competencies in trained persons.*
- *Strive for consensus among all stakeholders.*

ORAL HEALTH PROGRAM

Untreated Dental Decay in Adults (HO OH-3): $35,000 designated to the continuation and expansion of a project designed to improve public health workforce competencies. Funds will be awarded to the Office of Oral Health and Dentistry, NDHHS. The Oral Care Toolkit is a collaborative project of the Office of Oral Health and Dentistry (OOHD) and the UNMC College of Dentistry, using PHHSBG dollars to develop and launch training among Dental Hygienists holding Public Health Authorizations, enabling them to teach caregivers for elderly persons in care facilities to provide care for their residents. Another potential audience for the training are caregivers for persons with developmental disabilities. The OOHD will increase awareness of the importance of oral health to overall health and proper self-care for their children and for themselves. Activities include:

- *Establish contract/subgrant with UNMC College of Dentistry.*
- *Monitor and evaluate effectiveness and reach of prevention, education and/or oral health care awareness services.*
- *Investigate expansion of target audience to caregivers for developmentally disabled persons.*

Low-income children and youth preventive services (HO OH-8) $79,549 designated to reactivate local prevention services aimed at children under the age of 10. Services will be modeled on those offered in a successful HRSA grant, "Oral Health Access for Young Children" include *provision of fluoride varnish treatments, education, and referrals to dental homes primarily among children living in underserved areas and from low-income families. Funds will be awarded to the office of Oral Health and Dentistry, NDHHS. Activities include:*

- *Develop and issue RFA to local health departments, FQHC's and other local non-profit entities.*
- *Establish partnerships through contracts or subgrants.*
- *Monitor and evaluate effectiveness and reach of services, including clinical quality assurance of preventive services offered.*

Oral Health Surveillance System (HO OH-16) $40,000 designated for the development of a comprehensive oral health surveillance system, in collaboration with the Epidemiology and Informatics Unit for the use of the OOHD and partners. *The surveillance system will enable the NDHHS to establish and track oral health status and service need among various populations in Nebraska. The surveillance system will be used to support future funding requests and to document the effectiveness of oral health interventions. Funds will be awarded to the Office of Oral Health and Dentistry, NDHHS, allowing them to subgrant the funds to continue the project created by the University of Nebraska Medical Center, College of Dentistry under subcontract. Activities include:*

- *Develop oral health surveillance system, including researching available models.*
- *Test the oral health surveillance system.*
- *Monitor and evaluate the effectiveness of the surveillance system.*

PUBLIC HEALTH INFRASTRUCTURE PROGRAM

End Stage Renal Disease (HO CKD-14) *$100,000 reserved for creation of an automated computerized record keeping and payment management system for the Nebraska Chronic Renal Disease Program. This will be a one-time cost to research, develop and test the system to replace the fully manual system that has existed since the inception of the program. The system capacity will include data availability for enrollments approved, agreements signed and claims processed. Funds will be awarded to a contractor*

selected by the Nebraska Chronic Renal Disease Program. Activities include:

- *Research, design and develop the record keeping and payment processing system.*
- *Test the system and monitor performance of contractor.*

Community-Based Primary Prevention Services (HO ECBP-10) *$300,0000 reserved for development of 10 community-based prevention projects and increasing access to healthy foods and beverages in underserved areas. Funds will be awarded to local health departments, tribal health departments and other local health entities that successfully compete fo subgrants. . Activities include:*

- *Select community-based projects to be completed. Monitor progress and provide technical assistance to subgrantees.*
- *Expand the "Snack & Go" project in convenience stores located near a middle or high school to promote healthier snack options.*

Data Availability - Healthy People 2020: (HO PHI-7*): $38,700 utilized to maintain Nebraska's health surveillance system at the state and local level and develop processes for collection and analysis of needed health data on all populations for use in development of health status indicators. Information will be provided to at least ten types of end users (decision makers, health planners, health program staff, medical and health professionals, community coalitions, and the public. Funds awarded to the NDHHS Community Health Planning and Protection Unit. Activities include:*

- *Data collection and analysis of 492 indicators, arranged in a multi-sheet spreadsheet which will enable narrative highlights of data analysis to be generated and used by local health departments and other agencies.*
- *Identification of relevant health indicators for Local Health Department (LHD) Reporting, update and execute analysis program, provide current data for use by LHDs, and generate and disseminate reports electronically.*
- *Preparation of the Nebraska HP2020 report of objectives including current rates and trends.*

Epidemiology Services (HO PHI-13): *utilize $277,200 to (1) sustain the Nebraska Joint Public Health Data Center and (2) increase informatics capacity of NDHHS. The Epidemiology and Informatics Unit will work in collaboration with the UNMC College of Public Health to maintain all the critical functions of the Nebraska Joint Public Health Data Center. The JNC was developed to be a comprehensive public health data inventory, performed data linkages, established a master data index, developed and implemented query system, conducted studies, assisted in internal trainings to improve epidemiology and statistics competencies of NDHHS staff, and provided technical assistance in data linkages and analyses. Funds awarded to the Epidemiology and Informatics Unit, NDHHS and the University of Nebraska Medical Center, College of Public Health. Activities include:*

- *Assure adequate staffing to sustain all existing critical functions of the Nebraska Joint Public Health Data Center, overseen by advisory group made up of NDHHS and UNMC College of Public Health leadership staff.*
- *Recruit, hire and train one highly-qualified Informatician; monitor work and report progress.*

Health Improvement Plans (HO PHI-15*): $599,500 utilized to increase the capacity of Nebraska's governmental public health agencies to carry out all three Core Functions and all 10 Essential Services of Public Health, focusing primarily on the funded programs within the NDHHS Division of Public Health and 18 LB692* Local/District Public Health Departments.*

**LB692 was the legislative bill under which the current system of district health departments was established and is funded beginning in May 2001. For the first time, all 93 Nebraska counties are covered by local/district health departments.*

Funds are awarded to the Community and Rural Health Planning Unit. Activities include:

- *Implement five key strategies from State health improvement plan.*
- *Monitoring and technical support by the PHHS Block Grant Coordinator to subawardees to ensure progress.*
- *Provision of technical assistance to local/district health departments by Nebraska DHHS staff. Training opportunities will also be provided.*
- *Provision of additional funding to local health departments to implement evidence-based programming. Funds will be leveraged from state and other federally funded programs, pooled to provide financial assistance.*

- *Provision of training sessions and mentoring to local/district health department staff members to increase their capacity to write grants, develop and implement health promotion programs, improve programming, and evaluate interventions and activities.*

Accredited Public Health Agencies (HO PHI-17*: $47,700 to be used to increase the proportion of state public health agencies that are accredited in Nebraska. Funds will be awarded to the Community and Rural Health Planning Unit, NDHHS Activities include:*

- *Application for Public Health Accreditation to be submitted by the Nebraska Division of Public Health.*

UNINTENTIONAL AND INTENTIONAL INJURY PROGRAM

Sexual Assault-Rape Crisis (HO IPV-40)*: $42,000. This amount slightly exceeds the mandatory allocation for this set-aside. The funds are awarded to the Nebraska Department of Health and Human Services (NDHHS) Injury Prevention and Control Program to support subawards of the funds to the Nebraska Domestic Violence Sexual Assault Coalition which operates more than 20 local rape services across the state. The Injury Prevention Program also operates the larger Rape Prevention Grant, which complements the PHHSBG Set-Aside. Activities include:*

- *Maintain and improve the primary prevention social marketing campaign promoting bystander engagement and healthy relationships ("Step Up Speak Out").*

Traumatic Brain Injury (HO IVP-2)*: $62,000 utilized to reduce the number of traumatic brain injuries needing emergency department visits or hospitalizations in Nebraska children. Funds are awarded to the NDHHS Injury Prevention Program. Activities include:*

- *Injury prevention programming to reduce traumatic brain injuries from bicycle crashed and falls at home in children.*

Partner with the Brain Injury Association of Nebraska to provide and guide concussion education, awareness and prevention across the state.

Age-Appropriate Child Restraint Use (HO IVP-16)*: $62,000 utilized to increase the observed use of child restraints. Funds are awarded to the NDHHS Injury Prevention Program. Activities include:*

- *Provision of child passenger safety training, including technical assistance, in conjunction with the Nebraska Child Passenger Safety Advisory Committee and Safe Kids Nebraska.*
- *Provision of technical assistance to Child Passenger Safety Technicians providing child passenger advocacy trainings.*
- *Allocation of at least 10 mini-grants to local technicians to conduct child passenger safety seat checks in their communities.*
- *Coordinate Child Passenger Safety Training for child care providers related to child passenger safety transportation legislation.*
- *Nebraska DHHS continues to serve as an authority on child safety seat use and restraint laws, encouraging participation in Child Passenger Safety Week and providing information to child care centers about the Safe Kids Nebraska Child Care Transportation Training.*

Deaths from Falls (HO IVP-23): $56,000 utilized to reduce death and injury rates, as well as reduce hospitalizations and emergency department visits, due to falls. Funds are awarded to the NDHHS Injury Prevention Program. Activities include:

- *Preventing older adult falls by implementing Tai Chi classes.*
- *Educating public health partners, community partners and the public on the scope of the problem of older adult falls in Nebraska and provide evidence-based prevention strategies.*
- *Participation during national Older Adult Falls Prevention Day providing education on older adult falls prevention at local community events and through media releases.*
- *Support of Tai Chi instructors through update trainings and development opportunities (which include technical assistance and site visits by a Tai Chi consultant).*
- *Establishing 5 sites to offer Stepping On, an evidence-based falls prevention program.*

WORKSITE WELLNESS PROGRAM

Worksite Health Promotion Programs (HO ECBP-8*: $183,000 utilized to strengthen and support Nebraska's worksite wellness councils and expand involvement of local health departments in facilitating establishment and improvement of worksite wellness activities among Nebraska's businesses, large and small. Funds are awarded to the WorkWell Council operated by the Nebraska Safety Council, to the Panhandle Worksite Wellness Council operated by the Panhandle Public Health District and to WELCOM (Wellness Council of the Midlands). Activities include:*

- *Implement sustainability strategies for physical activity access projects, healthy eating initiatives and breastfeeding interventions within worksites.*
- *Build capacity of local worksite wellness councils to promote adoption of best practice interventions to protect the health and safety of the workforce.*
- *Worksite Wellness Councils provide technical assistance and training to local businesses in order to establish and grow worksite wellness activities at those sites.*
- *Enhance communication among worksite wellness councils and local health departments encouraging collaboration and continued investment / leveraging of business and community resources.*

***Administrative costs**: Nebraska equates "Administrative Costs" with "Indirect Costs" which are charged against salary and fringe benefits of the staff supported by the PHHSBG funds in accordance with our current federally approved Indirect Cost Rate (46.2%). However, we do not exceed the cap imposed on Administrative Cost (10% of the final amount allocated to the state for the fiscal year). The NDHHS uses the funds to support efficient operation of the PHHS Block Grant: provision of legal services, accounting services, personnel services, information technology services; office space, utilities, printing, phone, building and equipment maintenance.*
Nebraska's PHHS Block Grant Work Plan (grant application) for FY2014 was prepared under federal guidelines, which require that states use funds for activities directed toward the achievement of the National Health Promotion and Disease Prevention Objectives in Healthy People 2020. All funded projects are also required to plan and conduct their interventions using evidence based strategies, best or promising practice, whenever such models are available.

Funding Priority: Under or Unfunded, Data Trend

Statutory Information

Advisory Committee Member Representation:

Advocacy group, American Indian/Alaska Native tribe, College and/or university, Community-based organization, Community health center, County and/or local health department, Dental organization, Minority-related organization, State health department, State or local government

Dates:	
Public Hearing Date(s):	**Advisory Committee Date(s):**

Current Forms signed and attached to work plan:

Certifications: No
Certifications and Assurances: Yes

Budget Detail for NE 2014 V0 R0	
Total Award (1+6)	$2,536,795
A. Current Year Annual Basic	
1. Annual Basic Amount	$2,495,960
2. Annual Basic Admin Cost	($249,596)
3. Direct Assistance	$0
4. Transfer Amount	$0
(5). Sub-Total Annual Basic	$2,246,364
B. Current Year Sex Offense Dollars (HO 15-35)	
6. Mandated Sex Offense Set Aside	$40,835
7. Sex Offense Admin Cost	($4,083)
(8.) Sub-Total Sex Offense Set Aside	$36,752
(9.) Total Current Year Available Amount (5+8)	$2,283,116
C. Prior Year Dollars	
10. Annual Basic	$0
11. Sex Offense Set Aside (HO 15-35)	$0
(12.) Total Prior Year	$0
13. Total Available for Allocation (5+8+12)	$2,283,116

Summary of Funds Available for Allocation	
A. PHHSBG $'s Current Year:	
Annual Basic	$2,246,364
Sex Offense Set Aside	$36,752
Available Current Year PHHSBG Dollars	$2,283,116
B. PHHSBG $'s Prior Year:	
Annual Basic	$0
Sex Offense Set Aside	$0
Available Prior Year PHHSBG Dollars	$0
C. Total Funds Available for Allocation	$2,283,116

Summary of Allocations by Program and Healthy People Objective

Program Title	Health Objective	Current Year PHHSBG $'s	Prior Year PHHSBG $'s	TOTAL Year PHHSBG $'s
DIABETES PROGRAM	D-3 Diabetes Deaths	$73,900	$0	$73,900
Sub-Total		**$73,900**	**$0**	**$73,900**
EMERGENCY MEDICAL SERVICES PROGRAM	AHS-8 Rapid Prehospital Emergency Care (EMS)	$30,000	$0	$30,000
Sub-Total		**$30,000**	**$0**	**$30,000**
INFECTIOUS DISEASE PROGRAM	HIV-2 New HIV Infection	$54,000	$0	$54,000
	STD-1 Chlamydia	$30,000	$0	$30,000
	STD-6 Gonorrhea	$21,750	$0	$21,750
Sub-Total		**$105,750**	**$0**	**$105,750**
MINORITY HEALTH PROGRAM	ECBP-11 Culturally Appropriate Community Health Programs	$77,400	$0	$77,400
	PHI-2 Continuing Education of Public Health Personnel	$25,000	$0	$25,000
Sub-Total		**$102,400**	**$0**	**$102,400**
ORAL HEALTH PROGRAM	OH-3 Untreated Dental Decay in Adults	$35,000	$0	$35,000
	OH-8 Dental Services for Low-Income Children and Adolescents	$79,549	$0	$79,549
	OH-16 Oral and Craniofacial State-Based Health Surveillance System	$40,000	$0	$40,000
Sub-Total		**$154,549**	**$0**	**$154,549**
PUBLIC HEALTH INFRASTRUCTURE PROGRAM	CKD-14 End-Stage Renal Disease Deaths	$100,000	$0	$100,000
	ECBP-10 Community-Based Primary Prevention Services	$310,000	$0	$310,000
	PHI-7 National Data for Healthy People 2020 Objectives	$38,700	$0	$38,700
	PHI-13 Epidemiology Services	$277,200	$0	$277,200
	PHI-15 Health Improvement Plans	$599,500	$0	$599,500
	PHI-17 Accredited	$47,700	$0	$47,700

	Public Health Agencies			
Sub-Total		**$1,373,100**	**$0**	**$1,373,100**
UNINTENTIONAL AND INTENTIONAL INJURY PROGRAM	IVP-2 Traumatic Brain Injury	$82,000	$0	$82,000
	IVP-16 Age-Appropriate Child Restraint Use	$62,000	$0	$62,000
	IVP-23 Deaths from Falls	$101,000	$0	$101,000
	IVP-40 Sexual Violence (Rape Prevention)	$37,917	$0	$37,917
Sub-Total		**$282,917**	**$0**	**$282,917**
WORKSITE WELLNESS PROGRAM	ECBP-8 Worksite Health Promotion Programs	$160,500	$0	$160,500
Sub-Total		**$160,500**	**$0**	**$160,500**
Grand Total		**$2,283,116**	**$0**	**$2,283,116**

State Program Title: DIABETES PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Diabetes Program*** is dedicated to preventing death and disability due to diabetes. The program focuses on people living with diabetes or at risk for developing diabetes and on diabetes care providers. The program works in both rural and urban areas of the state.

Health Priorities: During 2012, 442 Nebraska residents died from diabetes (diabetes was the first-listed cause of death on their death certificate). This number translates into a mortality rate of 20.7 deaths per 100,000. Diabetes also remained the seventh leading cause of death among Nebraska residents in 2012.

Primary Strategic Partners:

- External: Community Action Partnership of Western Nebraska; Nebraska Medical Center Diabetes Program at OneWorld Community Health Center; CIMRO of Nebraska (Quality Improvement Organization for Nebraska); Public Health Association of Nebraska, local county and district health departments and others.
- Internal: NDHHS programs which include: Programs that work with the CDC 1305 grant which include the Heart Disease and Stroke Program, and the Nutrition and Activity for Health (NAFH) Program. Other internal programs include the Comprehensive Cancer Program, Office of Health Disparities and Health Equity, Community and Rural Health Planning, and Breast and Cervical Cancer Program/WISEWOMAN program.
- BRFSS: Survey and study partners: External -- CDC, Local Public Health Departments, University of Nebraska Medical Center (UNMC). Internal -- NDHHS programs including Child Protective Services, Behavioral Health, Tobacco Free Nebraska, Nebraska State Patrol, and Comprehensive Cancer Program. Users of survey results and reports -- Legislators, NDHHS programs, Local Public Health Departments, University of Nebraska, Voluntary Associations, general public (both printed and electronic data access).

Evaluation Methodology:

- The NDHHS Division of Public Health, Epidemiology & Informatics and Vital Records collect and report data including Behavioral Risk Factor Surveillance (BRFSS) data and cause of death information.
- The two contracting diabetes self-management education programs gather data on the number of individuals that have an A1c test and compare to previous years data.
- The Diabetes Prevention Program tracks the number of hits to the website. A diabetes risk assessment test is available on the website. Numbers that take the risk test are collected.
- Numbers of people attending self-management sessions are collected.
- Diabetes and pre-diabetes data from the Behavioral Risk Factor Surveillance System (BRFSS) are used to monitor the prevalence of diabetes and pre-diabetes, along with diabetes risk factors among a representative sample of adult residents in Nebraska. Data from the BRFSS diabetes modules are used to monitor (among people who have been diagnosed with diabetes) the proportion who receive certain key preventive health services (A1c tests, dilated eye exams, foot exams, and visits to a health professional for diabetes), the percentage who have ever taken a diabetes education class, and the proportion of those who practice self-care management (self-monitoring of blood glucose, foot self-exams, and the prevalence of retinopathy or related symptoms).

State Program Setting:

Community based organization, Community health center, Faith based organization, Medical or clinical site, Senior residence or center, State health department, Work site, Other: Website

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO D-3 Diabetes Deaths

State Health Objective(s):

Between 10/2013 and 09/2018, **maintain the diabetes death rate at no more than 75 per 100,000 population.**
This rate pertains to those deaths where diabetes was mentioned anywhere on the death certificate.

Baseline:
During the most recent year for which death data is available (2012), the age-adjusted diabetes-related mortality rate for Nebraska residents was 20.7 deaths per 100,000 population.

Data Source:
NDHHS Vital Records (2012), based on death certificates, and the Behavioral Risk Factor Surveillance System (BRFSS).

State Health Problem:

Health Burden:
People with diabetes account for death rates two to four times greater that people without diabetes.

- In 2012 an estimated 8.1% of Nebraska adults had diagnosed diabetes which is a significant increase from the rate of 4.4% recorded in 1995.
- BRFSS data from 2011 also indicate that there are 6.2% (77,839) adults in Nebraska who have been diagnosed with pre-diabetes, although the total adult population with pre-diabetes, including diagnosed and undiagnosed cases, may be as high as 450,000.
- BRFSS data in 2012 also show that men (8.3%) are more likely to have diabetes than women (7.9%), and that the percentage of adults with diabetes is greatest among those with the least education and the lowest household income.
- Significant racial and ethnic disparities also exist, with African-Americans, Native Americans, and Hispanics in Nebraska all at high risk for developing diabetes. After adjusting for age differences, the percentage of African-American (12.0%), Native American (11.2%) and Hispanic(11.5%) adults in Nebraska who have been diagnosed with diabetes is significantly higher than the percentage for whites (7.2%), according to BRFSS data.
- Also of concern is the increasing prevalence of diabetes among the elderly, particularly since Nebraska's population is getting older. In 2012 almost one of every six (17%) Nebraska residents age 65 and older had diagnosed diabetes, compared to only about one in 10 (10.8%) at the start of the decade. With the size of Nebraska's 65-and-older population projected to increase almost 50% during the next two decades (from 264,000 in 2012 to 375,000 in 2030), the number of people in Nebraska who have diabetes will probably not decrease any time soon.
- People who have diabetes also suffer an increased risk of developing a number of disabling and life threatening complications, including heart disease, stroke, kidney failure, blindness, neuropathy (inflammation and degeneration of peripheral nerves), and peripheral vascular disease, which can ultimately lead to amputation of the lower extremities. In addition to obesity and lack of physical activity, high blood pressure (hypertension), cigarette smoking, and high cholesterol are known risk factors for both coronary heart disease and stroke. High blood pressure is also a risk factor for diabetes related blindness, kidney disease, neuropathy, and peripheral vascular disease, and contributes to the progress of these diseases after their onset. Cigarette smoking and high cholesterol are risk factors for peripheral vascular disease, while smoking can hasten the decline of kidney function among people with diabetes.
- In 2013, according to the American Diabetes Association, the direct and indirect cost of diabetes in the

United States totaled approximately $245 billion.

- According to the CDC's Chronic Disease Cost Calculator, the overall cost of diabetes in Nebraska was $715 million in 2010. *The estimate includes expenditures for office-based visits, home health care, vision aids, other medical supplies and equipment, prescription medicines, and nursing homes. Payer populations are not mutually exclusive. Costs for All Payers are calculated independently of costs for Medicaid, Medicare, and Private Insurers.*
- Also according to CDC's Chronic Disease Cost Calculator, that cost is expected to rise to $1,248 million, an increase of 60.9% by 2020. *The projections are medical costs only, including nursing home costs, but excluding absenteeism costs.*

Target Population:
Number: 100,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 60,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Behavioral Risk Factor Surveillance System, American Diabetes Association, NDHHS Vital Statistics, Youth Risk Behavioral Surveillance System, NDHHS "Impact of Diabetes in Nebraska" Report (July 2012).

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Diabetes Control and Complications Trial.
American Diabetes Association, Clinical Practice Recommendations, 2014.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $73,900
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $24,500
Funds to Local Entities: $24,500
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Diabetes Self-Management Interventions

Between 10/2013 and 09/2014, partners (NDHHS Diabetes Program, Community Action Partnership of Western Nebraska, and the Nebraska Medical Center working at OneWorld Community Health Center. will provide diabetes self-management education to **90** individuals with diabetes.

Annual Activities:

1. Diabetes Self-Management Projects.

Between 10/2013 and 09/2014, contract with two community-based clinics serving primarily minority and low-income clients (Community Action Partnership of Western Nebraska and Nebraska Medical Center Diabetes Program at OneWorld Community Health Center) to provide evidence-based diabetes self-management education and interventions, reaching a total of at least 90 new patients with diabetes.

- Community Action Partnership of Western Nebraska (CAPWN) will provide culturally appropriate diabetes self-management education and interventions for individuals with diabetes: Provide and conduct 12 diabetes education sessions, and one-on-one diabetes self-management education, smoking cessation information.
- The Nebraska Medical Center (NMC) Diabetes Program will provide evidence-based culturally appropriate diabetes self-management education and materials to patients at OneWorld Community Health Center. NMC will conduct one-on-one diabetes self-management education sessions.

Objective 2:

Increase Diabetes Prevention Awareness and Self-Management

Between 10/2013 and 09/2014, the Diabetes Prevention Program and Living Well Program will collect **the number of** individuals that attend diabetes prevention self-management education and chronic disease self-management leader training.

Annual Activities:

1. Promote Diabetes Prevention Program

Between 10/2013 and 09/2014,

- Promote diabetes risk test on website. Risk test will encourage those that find that they are at risk for diabetes to talk to their health care provider.
- Provide educational materials to health care providers on diabetes prevention activities and practices.
- Provide information to providers and the public on how to access and refer people at risk for diabetes to the National Diabetes Prevention Program (DPP).

2. Living Well Chronic-Disease Self-Management Leader Training

Between 10/2013 and 09/2014,

- Provide a Leader training to increase the number of leaders that are able to facilitate the chronic disease self-management sessions.

State Program Title: EMERGENCY MEDICAL SERVICES PROGRAM

State Program Strategy:

Program Goal:
The PHHS Block Grant-funded **Emergency Medical Services (EMS) Support Program** is dedicated to improving the capacity of local ambulance services to provide emergency care to the sick and injured in Nebraska. Cardiac emergencies are one of the more common calls to which EMS responds. The foci of the following activities are to improve public and/or patient recognition of a cardiac emergency, early access of the emergency medical response system and improve the EMS response to these victims. Current public education activities are helping to identify persons that have previously undiagnosed electrocardiogram changes and anomalies. Additionally, the public education activities in the rural areas are helping to introduce the public to the new capabilities of their local providers and the potential for the local ambulance to by-pass the nearest hospital and transport the patient to cardiac catheterization labs.

Health Priority:
Decrease the mortality and morbidity from myocardial infarctions. Based on the 2012 Nebraska Vital Statistics Report, death due to heart disease was the second leading cause of death.

Primary Strategic Partners:
External – Grand Island EMS & Fire, St. Francis Medical Center (Grand Island), Good Samarian Hospital & EMS (Kearney), North Platte EMS & Fire, Great Plains Regional Medical Center (North Platte), Bellevue Medical Center, Plattsmouth EMS, Bellevue EMS & Fire, Papillion EMS & Fire, Wymore EMS, Crete Area Medical Center, Crete EMS & Fire, Frontier County EMS, Louisville EMS & Fire, Alegent Creighton Health - Bergan Mercy Medical Center, Hastings EMS & Fire, Mary Lanning Medical Center, Hamilton County EMS, York EMS & Fire, Wahoo EMS & Fire, Fremont EMS & Fire, Donald Rice, MD., and the Cardiologists and Physicians associated with the aforementioned Hospitals.

Evaluation:
Create a written report which reflects the following:
- Number of Services and EMS providers attending cardiac emergencies classes.
- Number of services trained on 12-lead electrocardiogram (ECG) placement, data collection, and transmission of ECG data.
- Evaluation of a specific type of heart attack, ST-segment Elevation (in an ECG waveform) Myocardial Infarction (STEMI), Alert and Response System based on statewide EMS model protocols.
- Number and type public education activities.
- A summary public education and activities in regards to cardiac emergencies as provided by EMS.

State Program Setting:
Medical or clinical site, Other: Rural and Suburban Ambulance Services, Critical Access Hospitals, & Cardiac Catheterization Labs

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Statewide Education & Training Coordinator
State-Level: 9% Local: 0% Other: 0% Total: 9%

Total Number of Positions Funded: 1
Total FTEs Funded: 0.09

National Health Objective: HO AHS-8 Rapid Prehospital Emergency Care (EMS)

State Health Objective(s):

Between 10/2013 and 09/2018, reduce heart disease mortality in the targeted counties by 5%

Baseline:
Heart Disease Deaths in 2012

	Total Deaths	Age Adjusted Per 100,000
Statewide	***3305***	***146.8***
Adams	92	212.3
Buffalo	69	129.8
Cass	39	127.1
Dodge	70	112.0
Frontier	7	146.7
Gage	50	131.7
Hall	91	127.1
Hamilton	24	161.9
Lincoln	80	162.5
Saline	46	241.6
Sarpy	162	132.7
Saunders	35	125.0
York	27	108.5

Data Source:
Nebraska Vital Statistics Report (2012)

State Health Problem:

Health Burden:
In 2012, death as a result of heart disease was second only to cancer in Nebraska. Twenty-one percent of deaths in Nebraska were a result of heart disease (146.8 deaths per 100,000 population). "With only 176 fewer deaths than cancer, heart disease was the second leading cause of death among Nebraska residents in 2012, and was responsible for 3,305 deaths. Among people age 75 and older, heart disease was also the state's leading cause of death in 2012, by a count of 2,397 to 1,677 for cancer." (2012 Nebraska Vital Statistics Report)
Ability to capture and evaluate a 12-lead ECG in the field may lead to fewer deaths from STEMI by routing affected patients to facilities with cardiac catheterization labs. STEMI stands for ST-Segment Elevation Myocardial Infarction, denoting a particular type of heart attack with a specific electrocardiogram waveform.
Defense against death as a result of a cardiac emergency remains in the hands of the patient and the public to both recognize and respond early to the event. During a cardiac emergency accessing the local emergency response system will aid in the patients survival. Also playing a major role in patient survival is the early attainment and interpretation of an ECG by a qualified medical provider.

Target Population:
Number: 363,676
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 363,676
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Specific Counties
Target and Disparate Data Sources: US Census, 2012 Nebraska Vital Statistics Report (2012)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: National Association of Emergency Medical Services Physicians

Millin MG, Brooks SC, Travers A, Megargel RE, Colella MR, Rosenbaum RA & Aufderheide TP. (July/September 2008). Emergency Medical Services Management of ST-Elevation Myocardial Infarction. Prehospital Emergency Care, Volume 13(3).

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $30,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $5,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Create, implement and/or enhance STEMI Response System/s
Between 10/2013 and 09/2014, NDHHS EMS Support Program will provide update training and technical assistance in the creation or further enhancement of cardiac emergency response systems to **5** EMS Services.

Annual Activities:
1. Provide Technical Assistance and Expertise
Between 10/2013 and 09/2014, create, implement and/or enhance rapid transport system/s for STEMI patients to definitive care. This may include assistance from an information technology and/or STEMI system expert.

2. Educate public response to cardiac emergency
Between 10/2013 and 09/2014, conduct localized training on the recognition of a cardiac emergency, accessing the 911 system, retrieving and placing an automatic defibrillator on the patient.

Objective 2:
Perform local training
Between 10/2013 and 09/2014, the NDHHS EMS Support Program will provide Cardiac Emergency Response Training to **5** Ambulance Services in Nebraska.

Annual Activities:
1. Provide Cardiac Emergency Response Training
Between 10/2013 and 09/2014, the NDHHS EMS Support Program will provide education and training to **5** ambulance services on Cardiac Emergency Response.

2. Attain ECG in the field
Between 10/2013 and 09/2014, educate 3 rural Services to attain an ECG in the field and transmit the patient care file in e-NARSIS or other appropriate information system/s.

3. ECG data retrieval
Between 10/2013 and 09/2014, educate the staff of 3 receiving facilities to retrieve patient care and ECG information from e-NARSIS or other information systems.

Objective 3:
Provide public awareness training on cardiac emergencies
Between 10/2013 and 09/2014, NDHHS EMS Support Program will conduct **5** informational meetings at public events to increase awareness of cardiac emergencies among the general public.

Annual Activities:
1. Public Education
Between 10/2013 and 09/2014, provide at least three (3) Cardiac Emergency Awareness Trainings through the use of printed materials and subject matter experts at public events. One of these public education programs takes place at a regional medical center that pairs the public with healthcare professionals to discuss; risk factors, regional invasive cardiac care capabilities, EMS diagnostic and therapeutic modalities, and the importance of timely activation of the EMS system. Additionally, patients may choose to have a 12-lead electrocardiogram performed by the EMS staff and then have it interpreted by a cardiologist. Past events have identified several patients with previously undiagnosed cardiac problems.

State Program Title: INFECTIOUS DISEASE PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Infectious Disease Program*** is dedicated to limiting infection with two Sexually Transmitted Diseases (STDs), Chlamydia and Gonorrhea, as well as Human Immunodeficiency Virus (HIV) in Nebraska. This program provides free testing at selected sites for residents of Nebraska who are at risk of infection with HIV and STDs. Subsidizing the cost of laboratory testing makes testing accessible to all, increases awareness of disease status and ultimately helps prevent the spread of infection.

The Infectious Disease Program helps to accomplish the goals of two statewide disease control programs:

- NDHHS Sexually Transmitted Disease Program aims to control and prevent the transmission of STDs and reduce the disease burden and cost of treating these infections. By identifying cases among high risk populations at public clinics, the overall rate of infection will be reduced.
- NDHHS HIV Prevention Program aims to lower HIV infection, illness and death rates and create an environment of leadership, partnership and advocacy which fosters HIV prevention and the provision of services. By identifying cases among high risk populations, providing counseling and testing sites and related services, the overall rate of infection will be reduced.

Health Priorities:

STDs:

- Chlamydia is the most common STD in Nebraska, accounting for 5,553 cases in 2009.
- Gonorrhea is the second most common STD in Nebraska, accounting for 1,384 cases in 2009.

HIV/AIDS: During 2009, a total of 146 persons were diagnosed with HIV or Acquired Immunodeficiency Syndrome (AIDS) in Nebraska, as well as 1,673 persons were living with HIV/AIDS.

Primary Strategic Partnerships:

STDs: STD clinics, family planning facilities, correctional centers, student health centers, Indian Health Services, substance abuse centers and other medical facilities seeing persons with high-risk behaviors. Contractor: Nebraska Public Health Laboratory at the University Nebraska Medical Center (UNMC).
HIV/AIDS: Local health departments, Title X Family Planning Clinics, public health centers, correctional facilities, community-based organizations which provide HIV counseling and testing services across the state of Nebraska. Contractors: Nebraska Public Health Laboratory at UNMC, Heritage Laboratories in Kansas, Center for Disease Detection in Texas.

Evaluation Methodology:

Progress is tracked through the following means:
STDs: Monitoring performance of laboratory contractor through reports and billing, calculation of rates using U.S. Census figures for comparison, calculation of cost benefit using CDC formula.
HIV/AIDS: Monitoring performance of laboratory contractors through lab testing documents and billing, and clinic patient service forms, generating data using Counseling and Testing (CTS) and Program Evaluation and Monitoring System (PEMS).

State Program Setting:

Community based organization, Community health center, Faith based organization, Local health department, Medical or clinical site, Rape crisis center, Tribal nation or area, University or college, Work site, Other: Corrections facilities, libraries, haunted houses, concerts

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO HIV-2 New HIV Infection

State Health Objective(s):

Between 10/2013 and 09/2018, **Increase the percentage of high-risk persons tested for HIV/AIDS to at least 70% of total tests performed.**

Baseline:
Of the 5,924 tests performed in 2000, 62% (3,672) were involving high risk persons.

Data Source:
Nebraska's HIV Prevention Counseling, Testing and Referral Program.

State Health Problem:

Health Burden:

- **HIV/AIDS Incidence:** During 2012, 83 new cases of HIV/AIDS were diagnosed, reflecting an incidence rate of 4.5 cases per 100,000 population.

- **Prevalence:** At the end of 2012, 2,123 Nebraska residents were known to be people living with HIV/AIDS (PLWHA).
- **Overall AIDS Trends:** From 1983 to 2008, a total of 1,679 incident AIDS cases have been diagnosed among Nebraska residents. Since reporting of AIDS cases first started in 1983, the number of cases per year increased rapidly, reaching a peak of 99 cases in 1992. The number of AIDS cases remained stable from 1992 through 1995. Beginning in 1996, both the number of newly diagnosed AIDS cases and the number of deaths among AIDS cases declined sharply. This is primarily due to the success of new antiretroviral therapies including protease inhibitors. These treatments do not cure, but can delay progression to AIDS among persons with HIV (non-AIDS) and improve survival among those with AIDS. Since 1998, the number of reported AIDS cases in Nebraska has varied from 60 to 80 cases per year.

Target Population:
Number: 6,500
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 6,500
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: EvaluationWeb and Enhanced HIV/AIDS Reporting System (eHARS)

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Confirmation testing for HIV follows the process outlined by the Revised Recommendations for HIV Testing of Adults, Adolescents and Pregnant Women in Health-Care Settings, published by CDC, MMWR, September 22, 2006/55 (RR14); 1-17.

HIV counseling, testing and referral services follow the Revised Guidelines for HIV Counseling, Testing and Referral: Technical Expert Panel Review of CDC HIV Counseling, Testing and Referral Guidelines, published by the CDC MMWR, November 9, 3001/50 (RR19); 1-58.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $54,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
Less than 10% - Minimal source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
HIV Lab Testing
Between 10/2013 and 09/2014, the HIV Program, through contracting laboratory services and pre-purchase of rapid test kits, will conduct **6,000** tests, providing anonymous and confidential HIV testing at no cost to the client in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission.

Annual Activities:
1. HIV Samples Tested
Between 10/2013 and 09/2014, contract for laboratory testing on samples. Number of tests to be completed using PHHSBG funds:
- 40 HIV Confirmatory tests at $94 per test.
- 6,000 Rapid Tests at $12 per test.

National Health Objective: HO STD-1 Chlamydia

State Health Objective(s):

Between 10/2013 and 09/2018,
A. Reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending Family Planning clinics to no more than 6.0 percent positive.

B. Reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending STD clinics to no more than 14.0 percent positive.

C. Reduce the prevalence of *Chlamydia trachomatis* infections among Nebraska's adolescent and young adult males, aged 15 to 34 years, attending STD clinics to no more than 17.4 percent positive.

Baseline:

Target and baseline: Nebraska

Objective	Reduction in *Chlamydia trachomatis* infections	2010 Baseline	2015 Target
		Percent	
25-1A.	Females aged 15 to 34 years attending family planning clinics	6.0	6.0
25-1B.	Females aged 15 to 34 years attending STD clinics	15.0	14.0
25-1C.	Males aged 15 to 34 years attending STD clinics	18.0	17.4

Data Source:
Data source STD Program (STD*MIS/ELIRT)

State Health Problem:

Health Burden:
Preventing sexually transmitted diseases in clients living in disparity and in marginalized geographic locations of North Omaha, Nebraska, is difficult with only one community health center serving a densely populated metropolitan area. Reaching at risk adolescents in North Omaha, educating them of risky behaviors, availability of testing, treatment and partner notification, as well as prevention education is essential to reduce the spread of sexually transmitted diseases. In addition, there is a need increase non-traditional STD testing throughout high morbidity areas within North Omaha. Opening of new outreach sites at local Omaha libraries, concerts, health fairs, and student gatherings show promise. However, there is a lack of support for focused data driven efforts in North Omaha, leaving this population underserved.

The number of Chlamydia cases and rate -- among the target population estimated as 503,422 persons:
2010 -- 5,147 cases - rate 1,022 cases per 100,000 population
2011 -- 6,222 cases - rate 1,236 cases per 100,000 population
2012 -- 6,695 cases - rate 1,330 case per 100,000 population
2013 -- 6,917 cases - rate 1,374 cases per 100,000 population

Target Population:
Number: 503,422
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 25,616
Ethnicity: Non-Hispanic
Race: African American or Black

Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: U.S. Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Other: CDC Region VIII IPP Advisory Group, Gen Probe package insert, and CLIA and CAP guidelines of good laboratory practice.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $30,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $30,000
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Chlamydia/Gonorrhea Testing
Between 10/2013 and 09/2014, the STD Program, through contracting laboratory services, will conduct **3,500** tests for STDs at no cost to the client; reporting results in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission.

Annual Activities:
1. Chlamydia Samples Tested
Between 10/2013 and 09/2014, provide testing on samples from 131 provider sites. Numbers of tests to be completed:
- Chlamydia/Gonorrhea Gen Probe Amplified Tests= 3000.
- Chlamydia/Gonorrhea Gen Probe Urine Tests= 520.

National Health Objective: HO STD-6 Gonorrhea

State Health Objective(s):

Between 10/2013 and 09/2018,
A. Reduce the prevalence of *Gonorrhea* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending Family Planning clinics to no more than 0.4 percent positive.

B. Reduce the prevalence of *Gonorrhea* infections among Nebraska's adolescent and young adult females, aged 15 to 34 years, attending STD clinics to no more than 5.6 percent positive.

C. Reduce the prevalence of *Gonorrhea* infections among Nebraska's adolescent and young adult males, aged 15 to 34 years, attending STD clinics to no more than 7.5 percent positive.

Baseline:

Target and baseline: Nebraska

Objective	Reduction in *Gonorrhea* infections	2010 Baseline	2015 Target
		Percent	
25-2a.	Females aged 15 to 34 years attending family planning clinics	0.5	0.4
25-2b.	Females aged 15 to 34 years attending STD clinics	5.6	5.6
25-2c.	Males aged 15 to 34 years attending STD clinics	7.5	7.5

Data Source:
Data Source STD Program (STD*MIS/ELIRT)

State Health Problem:

Health Burden:
Preventing sexually transmitted diseases in clients living in disparity and in marginalized geographic locations of North Omaha, Nebraska, is difficult with only one community health center serving a densely populated metropolitan area. Reaching at risk adolescents in North Omaha, educating them of risky behaviors, availability of testing, treatment and partner notification, as well as prevention education is essential to reduce the spread of sexually transmitted diseases. In addition, there is a need increase non-traditional STD testing throughout high morbidity areas within North Omaha. Opening of new outreach sites at local Omaha libraries, concerts, health fairs, and student gatherings show promise. However, there is a lack of support for focused data driven efforts in North Omaha, leaving this population underserved.

The number of Gonorrhea cases and rate - among the target population estimated as 503,422 persons:
2010 -- 1,193 cases - rate 237 cases per 100,000 population
2011 -- 1,225 cases - rate 243cases per 100,000 population
2012 -- 1,367 cases - rate 272 cases per 100,000 population
2013 -- 1,190 cases - rate 237 cases per 100,000 population

Target Population:
Number: 503,422
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 25,616
Ethnicity: Non-Hispanic

Race: African American or Black
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years
Gender: Female
Geography: Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)

Other: CDC Region VII IPP Advisory Group Committee 2009, Gen Probe package insert, and CLIA and CAP guidelines of good laboratory practice.

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $21,750
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $21,750
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Chlamydia/Gonorrhea Testing
Between 10/2013 and 09/2014, the STD Program, through contracting laboratory services, will conduct **3,500** tests for STDs at no cost to the client; reporting results in order to facilitate follow-up on infected people, the aim of which is to assure change in risk behaviors and prevention of additional infection transmission.

Annual Activities:
1. Gonorrhea Samples Tested
Between 10/2013 and 09/2014, Contract with laboratory to provide testing on samples from 131 provider sites. Numbers of tests to be completed:
- Chlamydia/Gonorrhea Gen Probe Amplified Tests= 16,465.
- Chlamydia/Gonorrhea Gen Probe Tests= 11,056.
- GC cultures= 1,368.

State Program Title: MINORITY HEALTH PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Minority Health Program*** is dedicated to reducing disparities in health status among racial ethnic minorities residing in Nebraska.

Health Priorities:
- Identify disparities among racial ethnic minorities.
- Increase awareness of health disparities.
- Establish and maintain behavioral risk surveillance system for sub-groups of minority populations and refugees.
- Improve access to culturally competent and linguistically appropriate health services for racial ethnic minorities.
- Improve data collection strategies for racial ethnic and other vulnerable populations.
- Expand community-based health promotion and disease prevention outreach efforts to the aforementioned populations.

Specifically, the PHHS Block Grant-funded activities help assure that community health interventions and health promotion services are culturally tailored and linguistically appropriate in order to reduce health disparities.

Primary Strategic Partners: Local health departments, health care providers, community- and faith-based organizations, Native American tribes, the Statewide Minority Health Council, Public Health Association of Nebraska, Minority Health Initiative grantees, and University of Nebraska at Lincoln (UNL).

Evaluation Methodology: The Minority Health Program includes outcome and process evaluation methods:
- Pre- and post-tests to measure knowledge increase at education events, including chronic disease prevention, maternal child health, minority population growth and health disparity presentations.
- Copies of all publications printed: Nebraska Health Status of Racial and Ethnic Minorities report, report cards, and socio-economic report cards; and public health policy briefs on minority and disparity health issues.
- Invitation and attendance records.

State Program Setting:
Community based organization, Community health center, Local health department, State health department, Tribal nation or area

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO ECBP-11 Culturally Appropriate Community Health Programs

State Health Objective(s):
Between 10/2013 and 09/2018, identify at least 20 of the most critical health disparities and health needs

among racial ethnic minorities in Nebraska. Based on identified disparities and needs, work to equalize health outcomes and reduce health disparities through education of health care providers who serve these populations.

Baseline:

The following baseline data is including socioeconomic data, vital statistics, and behavioral risk factor surveillance system data.

American Community Survey

- Families living below the federal poverty level

  non-Hispanic White 9.9%
  African American 32.4%
  Asian 11.9%
  American Indian 38.5%
  Hispanic 23%

- Unemployed

  non-Hispanic White 4.2%
  African American 15%
  Asian 5%
  American Indian 18.6%
  Hispanic 7.9%

- Without high school education

  non-Hispanic White 8.6%
  African American 16%
  Asian 15.4%
  American Indian 25.4%
  Hispanic 48.2%

Nebraska Behavioral Risk Factor Surveillance System (BRFSS)

- Perceived Health Status: Fair or Poor

  non-Hispanic White 10.9%
  African American 19%
  Asian 9.1%
  American Indian 22.9%
  Hispanic 25.2%

- No Personal Physician

  Non-Hispanic White 13.8%
  African American 16.8%
  Asian 15.9%
  American Indian 23.5%
  Hispanic 35.1%

- Prevalence of Myocardial Infarction

  Non-Hispanic White 3.6%
  African American 3%
  Asian 3.5%
  American Indian 7.6%
  Hispanic 4.3%

- Prevalence of Stroke
  - Non-Hispanic White 2.2%
  - African American 3.8%
  - Asian 3.7%
  - American Indian 3.9%
  - Hispanic 2.3%
- Prevalence of Diabetes
  - Non-Hispanic White 6.7%
  - African American 12.7%
  - Asian 8.6%
  - American Indian 13%
  - Hispanic 13.8%
- Physical Inactivity
  - Non-Hispanic White 21.6%
  - African American 35.2%
  - Asian 21.5%
  - American Indian 28.3%
  - Hispanic 35.4%
- Body Mass Index: 30+
  - Non-Hispanic White 26.7%
  - African American 39%
  - Asian 10.3%
  - American Indian 41.7%
  - Hispanic 32%
- Mentally Unwell
  - Non-Hispanic White 10.1%
  - African American 13.1%
  - Asian 8.5%
  - American Indian 16.8%
  - Hispanic 9.1%

Nebraska DHHS Vital Statistics

- Infant Mortality(/1,000 births)
  - Non-Hispanic White 5.7
  - African American 13.8
  - Asian 2.8
  - American Indian 7.7
  - Hispanic 5.7
- First Trimester Prenatal Care
  - Non-Hispanic White 76.6%
  - African American 56.6%
  - Asian 67.3%
  - American Indian 50.1%
  - Hispanic 56.6%
- Teen Births (/1,000 Females ages 15-19)
  - Non-Hispanic White 23.5
  - African American 84.7
  - Asian 21.1

American Indian 100.2
Hispanic 114.6

- Heart Disease Mortality (/100,000 population)

  Non-Hispanic White 160.2
  African American 214.2
  Asian 64.5
  American Indian 131.7
  Hispanic 89.7

- Diabetes Mortality (/100,000 population)
  Non-Hispanic White 21.1
  African American 62.1
  Asian 18.7
  American Indian 93.2
  Hispanic 28.8
- Cancer Mortality (/100,000 population)
  Non-Hispanic White 171.8
  African American 238.3
  Asian 99.9
  American Indian 153.2
  Hispanic 99.5

Data Source:
2006-2010 BRFSS data, 2006-2010 Nebraska Vital Statistics data, 2006-2010 Birth data, 2010 U.S. Census Bureau ACS data.

State Health Problem:

Health Burden:
As compared to the White population of Nebraska:

African Americans
- Infant mortality rates 2.4 times higher.
- Low birth weight rates about two times higher.
- Highest rate of cancer (242.4/100,000 population vs. 175.8/100,000 White population).
- Highest mortality from heart disease (228.3 deaths/100,000 population) and are 1.3 times as likely to die of heart disease.
- All sexually transmitted diseases rate is 15 times as high (3,988/100,000 population vs. 256.6/100,000 White population).

American Indian and Alaska Natives
- Death rate due to diabetes is 4.4 times as high.
- Mortality rate due to suicide is 2.1 times as high.
- Second highest mortality rate from heart disease (192.4 deaths/100,000 population).
- Males were 1.5 times more likely to die from accidental or unintentional injury.
- A four times greater chance of all sexually transmitted diseases (1056.5/100,000 population) vs. White Nebraskans (256.6/100,000 population).

Multiple groups
- Teen birth rates are 4.9 times higher in Hispanic/Latinos and 4.3 times higher in American Indians.
- Life expectancy is lower for African Americans (72.2 years) and American Indians (70.7 years), compared to White Nebraskans (78.9 years).

- The incidence of diagnosed HIV/AIDS is greater in African Americans (13.9 times greater), American Indian (5.4 times greater), and Hispanics (4.7 times greater)*.

Source: Nebraska Vital Statistics (2006-2010); Nebraska Cancer Registry (2006-2010).

Target Population:
Number: 326,588
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 326,588
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander
Age: 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: U.S. Census 2010

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: National Standards on Culturally and Linguistically Appropriate Services CLAS (US Department of Health and Human Services, Office of Minority Health.)

Report to Congress: Assessment of the Total Benefits and Costs of Implementing Executive Order No. 13166: Improving Access to Services for Persons with Limited English Proficiency (US Department of Health and Human Services, Office of Minority Health)

BRFSS: The guidelines for doing BRFSS surveys was developed by the CDC - Behavioral Surveillance Branch, called the Behavioral Risk Factor Surveillance System Operational and User's Guide.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $77,400
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $34,000
Funds to Local Entities: $20,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
Less than 10% - Minimal source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Health Education and Health Disparities Presentations

Between 10/2013 and 09/2014, OHDHE will conduct **20** health education sessions in communities to raise knowledge and awareness of chronic diseases and maternal child health issues among minority populations across Nebraska. Minority adults in Nebraska will have increased understanding of how chronic disease issues and maternal child health impact their lives and health. Fifteen presentations will be conducted to increase awareness of minority population growth and health disparities among Nebraska minorities.

Annual Activities:

1. Chronic Disease Prevention and MCH Presentations

Between 10/2013 and 09/2014, OHDHE Community Health Educators will work with community-based organizations, local health departments, or other entities to provide at least 20 health education sessions targeting at least 100 minority adults to increase knowledge regarding maternal child health, chronic disease prevention and physical activity & nutrition.

2. Minority Population Growth and Health Disparity Presentations

Between 10/2013 and 09/2014, OHDHE will complete 15 cultural intelligence presentations/trainings with Minority Health Initiative grantees, stakeholders, and internal programs and external organizations. In these presentations, one module will be the Nebraska minority population growth and key disparities among minorities.

Objective 2:

Minority Data Collection and Analysis

Between 10/2013 and 09/2014, the Office of Health Disparities and Health Equity (OHDHE) will analyze **3** data sets and collect minority Behavioral Risk Factor data. Birth, death, and hospital discharge data will be used to identify health disparities among various racial ethnic groups throughout Nebraska.

Annual Activities:

1. Minority Hospital Discharge Data Project

Between 10/2013 and 09/2014, The Office of Health Disparities and Health Equity (OHDHE) will join together with DHHS and UNMC joint data center to work on an ongoing data linkage project to identify minority hospital discharge data, both emergency room, inpatient, and combined.

2. Summarize 2008-2012 Leading Cause of Death Data

Between 10/2013 and 09/2014, The OHDHE will identify the top 10 leading causes of death like cancer, heart disease, and stroke and the related disparities between minority groups and non-Hispanic Whites.

3. Summarize 2008-2012 Birth Data

Between 10/2013 and 09/2014, the OHDHE will identify the disparities between minority groups and non-Hispanic Whites related to maternal child health, like infant mortality and low birth weight.

4. Minority Surveillance Data Collection

Between 10/2013 and 09/2014, survey minority populations using the Nebraska Behavioral Risk Factor Surveillance System, adding 8 race, and reaction to race questions to the survey conducted by the University of Nebraska-Lincoln.

Objective 3:

Minority Reports

Between 10/2013 and 09/2014, OHDHE will update **3** groups of reports covering disparities in socioeconomic status, health status, and minority population growth.

Annual Activities:

1. Complete Socioeconomic Status Reports

Between 10/2013 and 09/2014, the OHDHE will identify and summarize key socioeconomic factors for Hispanics in Nebraska based on US Census Bureau 2009-2011 American Community Survey (ACS) data. And finalize the Nebraska Hispanic Socioeconomic Profile report. The OHDHE will also finalize and publish three Congressional District Socioeconomic Profile reports based on 2005-2009 ACS data. Between 10/2013 and 09/2014, based on US Census Bureau new CD boundary (Congress #113) 2008-2012 American Community Survey (ACS) data, the OHDHE will summarize the initial findings on key socioeconomic factors for minorities in Congressional District (CD) 1,Congressional District (CD) 2 and Congressional District (CD) 3.

2. Complete the Health status Reports

Between 10/2013 and 09/2014, update and finalize the Health Status for Nebraska's African Americans report and the Health Status for Nebraska's Hispanics report. These reports will present health status facts on the African American population and Hispanic population in Nebraska and will show the contrast between this minority population and the Non-Hispanic/Latino White majority population.

3. Complete Nebraska Disparity Report

Between 10/2013 and 09/2014, update and finalize the health disparities report for the state. This report provides a comprehensive look at many health-related issues and concerns and the disparate outcomes experienced by some of Nebraska's historically medically underserved minority residents. Regular updates ensure the report remains up-to-date and continues to be a useful resource for policymakers, service providers, and those interested in minority health issues.

4. Complete the Nebraska Minority Population Growth Report

Between 10/2013 and 09/2014, continue analyzing the US Census 2010 data to identify the changes in race, ethnicity, and total population within Nebraska. Create minority population maps by county and other maps. US Census Bureau data will be used to identify major changes in population distribution and growth among minority groups throughout Nebraska. Based on 2010 US Census data, OHDHE will update the Nebraska Minority Population Growth Report.

Objective 4:

Tribal Surveillance

Between 10/2013 and 09/2014, based on 3 pilot Behavioral Risk Factor Surveillance studies, OHDHE will identify **10** or more critical behavioral risk factors for three federally recognized Native American tribes - Ponca Tribe, Omaha Tribe and Winnebago Tribe.

Annual Activities:

1. Finalize Ponca Tribe Pilot BRFSS Project

Between 10/2013 and 09/2014, based on a pilot Behavioral Risk Factor Surveillance study, complete a preliminary report for the Ponca Tribe. This project will identify risk factors for tribe populations.

2. Finalize Winnebago Tribe Pilot BRFSS Project

Between 10/2013 and 09/2014, based on a pilot Behavioral Risk Factor Surveillance study, complete a preliminary report for the Winnebago Tribe. This project will identify risk factors for tribe populations.

3. Finalize Omaha Tribe Pilot BRFSS Project

Between 10/2013 and 09/2014, based on a pilot Behavioral Risk Factor Surveillance study, complete a preliminary report for the Omaha tribe. This project will identify risk factors for tribe populations.

National Health Objective: HO PHI-2 Continuing Education of Public Health Personnel

State Health Objective(s):

Between 10/2013 and 09/2018, Between 10/2014 and 9/2015, establish at least one system of suppport

for community health workers, has the capacity to identify and implement the core competencies, essential educational curriculum components, key roles and responsibilities.

Baseline:

No data source is available as this is a new project. There are currently no national standards for Community Health Workers (CHW's). This project is working establishing core competencies, essential educational curriculum components, key roles and responsibilities, and a system of support for community health workers. OHDHE is working on a survey to determine our baseline number of Community Health Workers in Nebraska.

CHWs have been used by local health departments, FQHCs, and several nonprofit agencies in Nebraska. For example, the Northeast Nebraska Public Health Department uses a CHW to assist its public health nurse on home visits to non-English speaking patients. The One World Community Health Center has used bilingual workers to provide assistance in enrolling children in Medicaid.
In addition, the Nebraska Breast and Cervical Cancer Program in DHHS has received grant funds to work with Nebraska's six FQHCs and five local health departments on using CHWs to promote and increase breast and cervical cancer screening in their communities. In a separate program, the Office of Health Disparities and Health Equity provides funds to train CHWs to work in underserved communities. These workers attempt to link individuals living in underserved communities with health care providers. They also provide culturally appropriate and accessible health education.

CHWs are already providing valuable services in some parts of Nebraska. However, there is still not a standard scope of services or a standard training curriculum. These standards should be determined based on input from organizations that are currently using CHWs and the CHWs who are working in the field.

Data Source:
No data source available. During this project time frame, OHDHE is working with the University of Arizona to collect baseline data for Community of Nebraska in Nebraska. The results from the University of Arizona will be our data source.

State Health Problem:

Health Burden:
Community Health Workers (CHWs) are becoming an integral part of the health care system. CHWs, also known as outreach workers, promotores, patient navigators, and lay health ambassadors, were recognized by the U.S. Department of Labor in 2009 and they were included in several sections of the Patient Protection and Affordable Care Act passed in 2010.

CHWs have several roles and responsibilities. They can move fluidly between the community and health care settings, bridging gaps in care, providing culturally appropriate education and services, and connecting families to needed clinical and social resources. Because CHWs develop peer-to-peer relationships with patients, rather than provider-client relationships, they can communicate more openly with patients on health issues.

CHWs have made important contributions to improving access to care and in changing the health knowledge, behaviors, and outcomes of people in the community. For example, improvements have been observed in conditions such as hypertension, diabetes, HIV/AIDS, cancer screening, immunizations, and maternal and child health in general. A recent study in New York City found that many CHWs are valued for their cultural competence and mediation skills between providers and members of diverse

communities. CHWs provided families with comprehensive asthma education, a home environmental assessment to identify and address household triggers, strategies to help families set goals, and referrals for clinical and social services.

In Nebraska, CHWs have been used by local health departments, FQHCs, and several nonprofit agencies. For example, the Northeast Nebraska Public Health Department uses a CHW to assist its public health nurse on home visits to non-English speaking patients. The One World Community Health Center has used bilingual workers to provide assistance in enrolling over 7,000 children in Medicaid.

In addition, the Nebraska Breast and Cervical Cancer Program in DHHS has received grant funds to work with Nebraska's six FQHCs and five local health departments on using CHWs to promote and increase breast and cervical cancer screening in their communities. In a separate program, the Office of Health Disparities and Health Equity provides funds to train CHWs to work in underserved communities. These workers attempt to link individuals living in underserved communities with health care providers. They also provide culturally appropriate and accessible health education.

CHWs are already providing valuable services in some parts of Nebraska. However, there is still not a standard scope of services or a standard training curriculum. These standards should be determined based on input from organizations that are currently using CHWs and the CHWs who are working in the field.

CHWs have the potential to work closely with the care coordinators in health care homes to change patient behaviors and improve outcomes. Their peer-to-peer relationships can improve compliance with medications to control hypertension, encourage cancer screening and timely immunizations, and educate patients about the importance of physical activity and eating more nutritious foods. They can target hard to reach individuals, help these individuals navigate our complex medical and social systems, and provide health education services in a culturally appropriate manner.

The changes in the Nebraska public health/health care landscape have created several new opportunities for integration. Some of these opportunities include the partnerships between nonprofit hospitals and local health departments in developing a community health needs assessment and implementation plan, and the development and implementation of the health care home model with its emphasis on improving the physical and behavioral health outcomes of patients. Once this model becomes the standard in most primary care clinics across the state, a logical next step is to address broader population health issues. Finally, CHWs offer a tremendous opportunity to integrate public health, behavioral health, and primary care services and building trust between individuals living in underserved communities and health care providers. All partners will need to work together to identify the necessary resources to implement these strategies. Although major challenges still remain, the integration of these critical services is within our reach. Improving health outcomes can only be achieved through a variety of collaborative partnerships and a focus on patients, families, and the community.

In the past, public health, mental health and substance abuse, and primary care services have generally been provided in isolation with minimal alignment. However, as the health care environment changes from volume-based to value-based reimbursement, there is potential to integrate these services and move the focus from individual care to population health.

Target Population:
Number: 50
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Health Care Systems, Research and

Educational Institutions, Other

Disparate Population:
Number: 50
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Other

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: COMMUNITY HEALTH WORKERS EVIDENCE-BASED MODELS TOOLBOX
HRSA OFFICE OF RURAL HEALTH POLICY (U.S. Department of Health and Human Servicies, HRSA)
Community Health Workers Toolkit (Rural Assistance Center)
Outcomes of Community Health Worker Interventions (Agency for Healthcare Research and Quality US)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $25,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Community Health Workers
Between 10/2014 and 09/2015, the Office of Health Disparities and Coalition contractor/subgrantee will develop **1** system to support community health workers.

Annual Activities:
1. Develop Contract to Facilitate and Coordinate Coalition
Between 10/2014 and 09/2015, the contractor will conduct a total of 10 meetings of the Nebraska Community Health Worker Coalition, steering committee and work groups to identify core competencies, essential educational curriculum components, key roles and responsibilities, and a certification process for community health workers in Nebraska.

2. Develop Certification Process for Community Health Workers
Between 10/2014 and 09/2015, the contractor will identify and begin an implementation process for certification of community health workers in Nebraska.

3. Monitor the Contract
Between 10/2014 and 09/2015, the OHDHE will monitor contracts for facilitator/coordinator and for certification implementation process.

State Program Title: ORAL HEALTH PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Oral Health Program*** is dedicated to improving and protecting the oral health status of Nebraskans across the lifespan. The Office of Oral Health and Dentistry (OOHD) will actively promote oral health awareness, dental disease prevention through to access of care.

Health Priorities: The program will focus on addressing dental disparities within the current health care system with special emphasis on young children and the elderly.

Primary Strategic Partners:

- External: Local county and district health departments, Federally Qualified Health Centers, Head Start and Early Head Start Programs, WIC, University of Nebraska Medical Center College of Dentistry and others.
- Internal: NDHHS programs which include: Epidemiology and Informatics Unit, Together for Kids and Families, Tobacco Free Nebraska Program, Office of Health Disparities and Health Equity, and Community and Rural Health Planning. Other internal programs include the programs that work with the CDC 1305 grant which include the Heart Disease and Stroke Program, Diabetes Program, and the Nutrition and Activity for Health (NAFH) Program.

Evaluation Methodology:

- The Oral Health Program will work with the NDHHS Division of Public Health, Epidemiology & Informatics Unit, and the Epidemiologist on staff in the Health Promotion Unit to develop an evaluation process for the oral health programs. A scan of available data sources was completed during the summer of 2012 which identified dozens of existing data bases that could be used in justifying program decisions and documenting progress.

State Program Setting:

Child care center, Community based organization, Community health center, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO OH-3 Untreated Dental Decay in Adults

State Health Objective(s):

Between 10/2013 and 09/2018, OOHD will design and implement at least one oral health program aimed at increasing awareness, improving access among adults 65 and older.

Baseline:

As of Spring of 2014 the OOHD now has a full staff including a Dental Health Director, Dental Health

Coordinator, and Program Staff Assistant. The director position was vacant since the Fall of 2011, and the coordinator position had been vacant since March 2013. Due to the lack of staffing the OOHD was unable to carry out program activities. At this time the OOHD is working on strategies to carry out priorities and reach target populations.

Data Source:
Office of Oral Health and Dentistry in NDHHS

State Health Problem:

Health Burden:
We have selected 3 measures of adult oral health status based on available data. The 2012 Nebraska Behavior Risk Factor Surveillance System (BRFSS) showed:
• 32.4% of the adults 18 and older did not visit a dentist or dental clinic for any reason during the past year.
• 39.8% of adults 18 and older reported having any permanent teeth extracted due to tooth decay or gum disease.
• 13.4% of adults 65 and older reported having had all of their teeth extracted due to tooth decay or gum disease.

Target Population:
Number: 258,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 258,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Nebraska BRFSS 2012, United States Census Bureau 2012

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

National Guideline Clearinghouse (Agency for Healthcare Research and Quality)

Other: Chandak A, McFarland KK, Nayar P, Deras M, Stimpson JP. Access to Oral Health Care in Nebraska. Omaha, NE: UMNC Center for Health Policy; 2013.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $35,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $30,000
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding

Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Improving Adult Oral Health Status
Between 10/2014 and 09/2015, Office of Oral Health and Dentistry with partners will implement **15** prevention, education, and/or oral health care awareness services for adults across the state.

Annual Activities:
1. Training Toolkit for Care Providers
Between 10/2014 and 09/2015, This "train the trainer" tool kit will assist in addressing workforce development issues in the state mentioned in *Access to Oral Health Care in Nebraska* article from April 2013. The tool kit was developed via a contract with the University of Nebraska Medical Center College of Dentistry that was supported by PHHSBG funds.

A contract with the University of Nebraska Medical Center College of Dentistry will be renewed to continue training additional Registered Dental Hygienist with a Public Health Authorization. The trained dental hygienist will train care providers for residents in long term care facilities and the developmentally disabled.

2. Adult Oral Health Awareness
Between 10/2014 and 09/2015, Three focus areas for awareness will be:
1) Oral health awareness is built into the training the care providers in long term care facilities will receive by the Registered Dental Hygienists with the Public Health Authorization.
2) Parents of young children who receive fluoride treatments will also receive education regarding the importance of good oral health care not only for their children, but the entire family.
3) Distribution of print media though local health agencies.

3. Monitoring and Evaluation
Between 10/2014 and 09/2015, the Dental Health Coordinator will monitor and evaluate the progress of trainings for Registered Dental Hygienists with a Public Health Authorization and trainings of care providers through periodic written reports, phone calls, and site visits. The Dental Health Coordinator will work with the Chronic Disease Epidemiologist, Jeff Armitage, and others identified within the Division of Public Health to evaluate the outcomes of the program.

National Health Objective: HO OH-8 Dental Services for Low-Income Children and Adolescents

State Health Objective(s):
Between 10/2013 and 09/2018, the OOHD will partner with at least four local health agencies to provide fluoride varnish treatments, education, and referrals to dental homes. The target audience will be children and their families through Head Start, Early Head Start, WIC, and other identified community programs where low-income families can be reached.

Baseline:
Existing FQHC's and a few local health departments already provide preventive services to children from low-income families. However, few of the 15 sub-grantees from the previous HRSA funded oral health program were able to sustain their activities.

Data Source:
Office of Oral Health and Dentistry in NDHHS

State Health Problem:

Health Burden:

- Tooth decay causes pain and can affect how kids eat, speak, play, learn and grow.[i]
- A 2005 survey of Nebraska 3rd graders showed that almost 60% had a history of tooth decay.[ii]
- Children living in rural areas of Nebraska are more likely to have oral health problems. [iii]
- Children in Nebraska without private insurance are more likely to have poor oral health. [iv]
- Nebraska children whose primary language is not English are over 10 times more likely to have poor oral health.[v]
- Of 43 pediatric dentists in 2011, only seven were located outside of Omaha and Lincoln.
- Fluoride varnish can effectively prevent tooth decay in high-risk children. [vi]

[i] CDC Division of Oral Health (2012). *Children's Oral Health*. Retrieved from http://www.cdc.gov/oralhealth/topics/child.htm
[ii] Nebraska Department of Health and Human Services (2005). *Open Mouth Survey of Third Graders, Nebraska 2005*. Lincoln, NE.
[iii] National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org.
[iv] National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org.
[v] National Survey of Children's Health. NSCH 2007. Data query from the Child and Adolescent Health Measurement Initiative, Data Resource Center for Child and Adolescent Health website. Retrieved from www.childhealthdata.org.
[vi] Barzel R, Holt K with Association of State and Territorial Dental Directors, Fluorides Committee. 2010. *Fluoride Varnish: An Effective Tool for Preventing Dental Caries*. 2010. Washington, DC: National Maternal and Child Oral Health Resource Center.
http://www.mchoralhealth.org/PDFs/FlVarnishfactsheet.pdf

Target Population:
Number: 13,200
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 13,200
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 1 - 3 years, 4 - 11 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: Oral Health Access for Young Children Program Final Report 2011-

2012, NDHHS, United States Census Bureau 2012

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Model Practices Database (National Association of County and City Health Officials)

Other: Association of State and Territorial Dental Directors (ASTDD) Best Practice Approach Prevention and Control of early Childhood Tooth Decay, http://www.astdd.org/prevention-and-control-of-early-childhood-tooth-decay/, February 2013

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $79,549
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $79,549
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Oral Health Access to Young Children
Between 10/2014 and 09/2015, 4-5 Local Community Health Departments, FQHC's, and community contractors will provide fluoride varnish treatments, education, and referral to a dental home to **1500** children and their families.

Annual Activities:
1. Fluoride varnish, education, and referral to dental home
Between 10/2014 and 09/2015, Local Health Departments, FQHC's, and community contractors will provide education combined with preventive therapy (fluoride varnish treatments) and the distribution of toothbrushes and fluoride toothpaste to clients in various public health settings which are non-traditional for dental care. The primary focus locations are: 1) WIC and related programs which provide services to new mothers, their children and families, 2) Early Health Start and Pre-School classes for ages 2-3 years, and Head Start classes for ages 4-5. These services will be taken to the patients, and will be provided by Registered Dental Hygienists with a Public Health Authorization.

2. Monitoring and Evaluation
Between 10/2014 and 09/2015, the Dental Health Coordinator will monitor and evaluate the progress of the 4-5 local community agencies through quarterly reports, conference calls, and site visits. The OOHD will ensure clinical quality control is in place for clinical screenings and application of fluoride varnish. The Dental Health Coordinator will work with the Chronic Disease Epidemiologist, Jeff Armitage, and others identified within the Division of Public Health to evaluate the outcomes of the program.

National Health Objective: HO OH-16 Oral and Craniofacial State-Based Health Surveillance System

State Health Objective(s):
Between 10/2014 and 09/2015, the OOHD will work with the Epidemiology and Informatics Unit to develop one Oral Health Surveillance System for the State of Nebraska.

Baseline:
At this time there is not an Oral Health Surveillance System for the State of Nebraska. A scan of available data sources was completed during the summer of 2012 which identified dozens of existing data bases that could be used in justifying program decisions and documenting progress.

Data Source:
Office of Oral Health and Dentistry in NDHHS

State Health Problem:

Health Burden:
At this time the State of Nebraska does not have an oral health surveillance system.

According to the Association for State and Territorial Dental Directors (ASTDD) best practice approach for a *State-based Oral Health Surveillance System* an oral health surveillance system should:

- Have a clear purpose and objectives. The purpose of the system indicates why the system exists, whereas its objectives relate to how the data are used for public health action.
- Contain a core set of measures/indicators that describe the status of important oral conditions or behaviors to serve as benchmarks for assessing progress in achieving good oral health (5).
- Analyze trends when several years of data are available.
- Communicate to decision maker and to the public the surveillance data and information in a timely manner and that the communication should enable decision makers at all levels to readily understand the implications of the information.
- Strive to put surveillance data to action to improve the oral health of residents in the state.

Additionally, the lack of an oral health surveillance system was identified in the *Access to Oral Health Care in Nebraska* as one of the barriers the state has related to Oral Health Care. The article states, "...oral Health surveillance dates is need to see where the state stands at present, to determine state deficiencies, and to work toward improving Nebraska's oral health status. However, Nebraska currently does not have an oral health surveillance system, which leads to less data available to evaluate the effectiveness of oral health improvement programs, and no clarity on where the state stands on some Healthy People 2020 objectives."

Target Population:
Number: 40
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 40
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Location: Entire state
Target and Disparate Data Sources: Association of State and Territorial Dental Directors (ASTDD), Access to Oral Health Care in Nebraska, UMNC Center for Health Policy; 2013

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Chandak A, McFarland KK, Nayar P, Deras M, Stimpson JP. Access to Oral Health Care in Nebraska. Omaha, NE: UMNC Center for Health Policy; 2013.

Association of State and Territorial Dental Directors (ASTDD), Best Practices Approach - State-Based Oral Health Surveillance System, http://www.astdd.org/state-based-oral-health-surveillance-system/, May 17, 2011.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $40,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Establish an Oral Health Surveillance System for Nebraska
Between 10/2014 and 09/2015, The Office of Oral Health and Dentistry and the Epidemiology & Informatics Unit will develop **1** surveillance system for the Oral Health program which will enable NDHHS to establish and track oral health status and service need among various populations in Nebraska.

Annual Activities:
1. Development of an Oral Health Surveillance System
Between 10/2014 and 09/2015,
- Identify who will be assigned from the Epidemiology & Informatics Unit to work on the development of the Oral Health Surveillance System.
- The OOHD and the assigned Epidemiology & Informatics Unit staff person will look at the current data situation related to oral health in Nebraska.
- The OOHD and the assigned Epidemiology & Informatics Unit staff person will look at other states surveillance systems as models for designing as system for Nebraska.
- Development of a functional surveillance system that can be used by the OOHD without the addition of staff members.

2. Testing the Oral Health Surveillance System
Between 10/2014 and 09/2015, the assigned Epidemiology & Informatics Unit staff person and the OOHD will test the surveillance system to make sure it provides the information need by the OOHD, and to make sure it is a user friendly system.

3. Monitoring of the Oral Health Surveillance System
Between 10/2014 and 09/2015, The OOHD and the assigned Epidemiology & Informatics Unit staff person will work together to monitor the functionality of the surveillance system, and the use of the data being collected.

State Program Title: PUBLIC HEALTH INFRASTRUCTURE PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Public Health Infrastructure Program*** is dedicated to supporting and strengthening Nebraska's capacity to protect the health of everyone living in Nebraska; primarily through organized governmental agencies, specifically the state health department and local/regional/tribal health departments. *(The program name was selected to reflect the public health planning, management and surveillance functions carried out.)*

Health Priorities: NDHHS selected as priority activities:

- Assuring availability of health data necessary and public health informatics expertise to planning and evaluating health programs and increasing the effectiveness of health department staff.
- Maintaining information and data resources at the state level in order to respond to requests for information from the local level, enable public health entities to conduct community needs assessment and provide a basis for formulating health policies and appropriate intervention strategies.
- Facilitating strategic planning at the state and local level, instituting performance standards and maintaining a well-trained public health workforce, critical to the success of all of the activities carried out by the NDHHS.
- Capacity building at the local level to provide all three Core Functions of Public Health and carry out all Ten Essential Services of Public Health.

Primary Strategic Partnerships:

- Health Data: External -- Local health departments, university researchers, university educators of health professionals, community-based organizations. Internal -- NDHHS Offices and Units within the Division of Public Health.
- Epidemiology and informatics capacity: UNMC, medical facilities, Nebraska Health Information Exchange
- Community Health Development: Local Public Health Departments (County and District), Public Health Association of Nebraska, National Association of County and City Health Officials (NACCHO), National Association of Local Boards of Health (NALBOH), Association of State and Territorial Health Officials (ASTHO), Nebraska Public Health Law Committee, Nebraska Turning Point Committee, UNMC College of Public Health.

Evaluation Methodology:

- Health Data: Report completion dates, data request response dates, data quality assurance procedures, and feedback from users of data.
- Community Health Development: Observation of operations of local public health departments, Reports from Local Public Health (LHD) Departments (including copies of their Health Improvement Plans, Performance Standards Assessment Results, Annual LHD Reports), Reports from contractors, observation of presentations by LHD staff.
- PHHS Block Grant Coordinator: Review of twice-yearly written reports from all subaward projects, site visit reports, personal and telephone contact.

State Program Setting:

Business, corporation or industry, Community based organization, Community health center, Local health department, Medical or clinical site, Schools or school district, Senior residence or center, State health department, Tribal nation or area, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: DHHS Program Manager II
State-Level: 50% Local: 0% Other: 0% Total: 50%
Position Title: Statistical Analyst III
State-Level: 21% Local: 0% Other: 0% Total: 21%
Position Title: Lead Program Analyst
State-Level: 29% Local: 0% Other: 0% Total: 29%
Position Title: Administrative Assistant I
State-Level: 100% Local: 0% Other: 0% Total: 100%
Position Title: DHHS Epidemiology Coordinator
State-Level: 100% Local: 0% Other: 0% Total: 100%

Total Number of Positions Funded: 5
Total FTEs Funded: 3.00

National Health Objective: HO CKD-14 End-Stage Renal Disease Deaths

State Health Objective(s):

Between 10/2013 and 09/2018, The NDHHS will select a contractor to develop 1 (one) automated/computerized record keeping and payment management system for the Nebraska Chronic Renal Disease Program. The system will be capable of efficiently tracking relevant data, processing payment of state funds to health providers (renal dialysis centers and pharmacies) and compiling status reports on services and expenditures.

Baseline:

The currently existing record keeping and payment processing system utilized by the Nebraska Chronic Renal Disease Program is entirely manual and paper-based. All transactions with health providers (renal dialysis centers and pharmacies) have been processed by hand since the inception of the state funded program 30 years ago. The manual system is labor-intensive, and does not automatically generate needed reports and other documents.

The new automated record-keeping system will have the ability to:

- Document day-to-day operations and assure efficient data processing.
- Store a chronological account enrollment; provider agreements signed, inquiries and responses; claims received, claims processed, claims paid;
- Facilitate communication with health care providers at the dialysis centers and pharmacies.
- Record the information received from NDHHs staff from outside the Chronic Renal Disease Program.
- Maintain the privacy and security of patient and provider records, and limit accessibility to authorized NDHHS personnel only.
- Inform proper fiscal management of processing and prepare for periodic financial audit.
- Inform analysis and evaluation of the Chronic Renal Disease Program including timeliness of services, problems encountered, and solutions undertaken.
- Provide needed data to NDHHS program planners and decision makers.

Data Source:
Nebraska Chronic Renal Disease Program, Department of Health and Human Services

State Health Problem:

Health Burden:

	ESRD Incidence Rate*		ESRD Prevalence Rate*	
	NE	US	NE	US
2007	355.3 (526)	354.7	1804.8 (2,565)	1669.4
2008	341.4 (514)	351.5	1831.9 (2,659)	1701.1
2009	331.8 (507)	355.7	1856.9 (2,748)	1735.4
2010	333.6 (540)	349.2	1883.4 (2,831)	1767.6
2011	304.8 (481)	336.2	1879.7 (2,859)	1791.1

*rates are expressed per million population; the numbers of Nebraska incident/prevalent cases are in parentheses

Nebraska's annual incidence rates for the past five years are consistently lower than the corresponding US rates (and going down), while Nebraska's prevalence rates are consistently higher than the concurrent US rates (and going up). Increasing prevalence indicates that the duration of the disease is getting longer (i.e., ESRD patients are surviving longer), and the differences between the Nebraska and US numbers suggests that ESRD patients in Nebraska survive longer than ESRD patients in the nation as a whole. The declining incidence rates in both Nebraska and the US suggest that various preventive efforts (e.g., better hypertension and diabetes control, effective management of declining kidney function before ESRD) are having a beneficial effect.

The total number of incident and prevalent cases in Nebraska for 2011 with various breakdowns of interest.

	Incident Cases*	Prevalent Cases*
Male	269 (55.9)	1,611 (56.3)
Female	212 (44.1)	1,248 (43.7)
0-19 years	11 (2.4)	59 (2.1)
20-44 years	62 (12.9)	472 (16.5)
45-64 years	182 (37.8)	1,342 (46.9)
65-74 years	113 (23.5)	549 (19.2)
75+ years	113 (23.5)	437 (15.3)
White	398 (82.7)	2,274 (79.5)
African-American	56 (11.6)	424 (14.8)
Native American	12 (2.5)	80 (2.8)
Asian American	15 (3.1)	74 (2.6)
Other	0 (0.0)	7 (0.2)
Hispanic	29 (6.0)	230 (8.0)
Non-Hispanic	452 (94.0)	2,629 (92.0)

*numbers in parentheses are the percentage of the total number of incident/prevalent cases (incidence, N=481; prevalence, N=2,859)

Rates calculated at the national level show that ESRD incidence and prevalence are higher among men and minority racial/ethnic populations, and increase with age. Even without the rate calculations for Nebraska, the same patterns hold true for Nebraska as well.

Source: US Renal Disease System website (www.usrds.org)

The Nebraska Chronic Renal Disease Program (CRDP) was established to provide assistance to Nebraska residents diagnosed with End Stage Renal Disease (ESRD) who cannot afford the cost of necessary dialysis treatment and medications. The state-funded program is administered by the Department of Health and Human Services (DHHS). Those state funds ($800,000 per year) may be used only to cover the costs of dialysis and medications; they cannot be used to design or operate a modern, automated payment management system or support staff salary and fringe to manage the program.

Creating a more efficient, automated/computerized payment management system will help assure prompt and accurate payments of the health providers (renal dialysis centers and pharmacies).

Target Population:
Number: 300
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes

Disparate Population:
Number: 300
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 25 - 34 years, 35 - 49 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: NDHHS, US Renal Disease System website

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

No Evidence Based Guideline/Best Practice Available

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $100,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Start-up
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Automated Data and Expenditure Tracking System
Between 10/2014 and 09/2015, the Nebraska Department of Health and Human Services and a contractor will develop **1** system to track services rendered, claims processed after submission by providers (renal dialysis centers and pharmacies) and track program expenditures.

Annual Activities:

1. Identify Contractor and Issue RFA

Between 10/2014 and 09/2015, Specifications will be established, RFA developed, technical assistance provided, applications processed and reviewed, contract negotiated and signed.

2. Monitor and evaluate program services

Between 10/2014 and 09/2015, Oversee the operation of the automated data and claims processing system and monitor performance of contractor.

National Health Objective: HO ECBP-10 Community-Based Primary Prevention Services

State Health Objective(s):

Between 10/2013 and 09/2018, implement at least 10 Community-based Prevention Projects aimed at reducing specific chronic disease and injury risk factors and implement "Snack E Go" in at least 4 additional retail establishments in underserved communities.

Baseline:

Chronic disease prevention and management and injury prevention are addressed by programs in the Division of Public Health, including those located within the Health Promotion Unit.

PHHS Block Grant and other federal and state funds are braided together to support collaborative programs that work with partners within the NDHHS and with stakeholders in agencies across the state. All programs design interventions using evidence-based guidelines.

Data Source:

Nebraska Department of Health and Human Services, Epidemiology and Informatics Unit

State Health Problem:

Health Burden:

Obesity and overweight: Obesity and overweight is a significant public health problem linked to many causes of death.

- Overweight and obesity are measured by an individual's body mass index (BMI) which is calculated as weight in kilograms divided by height in meters squared. Overweight (BMI=25.0-29.9) and obese (BMI=30.0+) individuals are at increased risk for many health conditions, including hypertension, type 2 diabetes, coronary heart disease, stroke, and some cancers. However, even modest weight loss (e.g., 5-10% of total body weight) is likely to produce health benefits.
- Two-thirds of adult Nebraskans (64.9%) were overweight or obese in 2010. The proportion of adults who are at risk due to obesity has risen considerably in recent years, increasing by nearly 7 percentage points between 2001 and 2010 for both Nebraska and the nation. In 2010, 27.5% of persons aged 18 and older in the U.S. and in Nebraska reported heights and weights that placed them in the "obese" category.

Diabetes: Over the course of the disease, diabetes can lead to a variety of disabling and life-threatening complications, including heart disease, stroke, blindness, kidney failure, nerve damage, and lower extremity amputation. People with diabetes are also subject to acute complications such as ketoacidosis, which is the result of severe insulin deficiency and can be fatal, while diabetes during pregnancy can have adverse effects on both mother and fetus. As a result, the risk of death among people with diabetes is about twice that of people of similar age but without diabetes.

- Prevalence of diagnosed diabetes among adults in Nebraska remained fairly constant at 4 to 5% between 1994 and 2001. Since then, prevalence has risen, reaching 7.7% in 2010. Based on the 2010 rate, more than 103,500 adult Nebraskans are estimated to have been diagnosed with this disease.
- BRFSS data from 2010 also indicate that there are over 76,000 adults in Nebraska who have been diagnosed with pre-diabetes, although the total adult population with pre-diabetes, including diagnosed and undiagnosed cases, may be as high as 450,000.
- American Indians had the highest rate for diabetes mellitus deaths (93.2/100,000), which was 4.4 times the rate for non-Hispanic Whites (21.1/1000, 000). African Americans had a rate of 62.1/100,000, which was 3.0 times the rate for non-Hispanic Whites. Hispanic Americans had a rate of 28.8/100,000, which was 1.4 times the rate for Whites.
- Type 2 diabetes, both obesity and lack of physical activity are significant risk factors, making lifestyle changes such as better nutrition, weight control, and regular physical activity highly advisable.

- In addition to obesity and lack of physical activity, high blood pressure (hypertension), cigarette smoking, and high cholesterol are known risk factors for both coronary heart disease and stroke. High blood pressure is also a risk factor for diabetes related blindness, kidney disease, neuropathy, and peripheral vascular disease, and contributes to the progress of these diseases after their onset. Cigarette smoking and high cholesterol are known risk factors for peripheral vascular disease, while smoking can hasten the decline of kidney function among people with diabetes.

Cancer: Cancer was Nebraska's leading cause of death in 2010, surpassing heart disease.
- By primary site, cancers of the lung, breast, prostate, colon and rectum occurred most frequently, accounting for more than half (51.1%) of all diagnoses.
- The Nebraska Cancer Registry recorded 8,887 diagnoses of cancer among Nebraska residents in 2010. The 2010 number translates into an incidence rate of 443.1 cases per 100,000 populations.
- In 2010, 3,437 Nebraska residents died from cancer, a number that translates into a rate of 166.5 cancer deaths per 100,000 population.

Heart Disease and Stroke: Heart disease and stroke were the second and third leading causes of death in Nebraska in 2010, with rates of 154.2 and 40.5 deaths per 100,000 populations respectively.
- Most CVD risk factors are modifiable through simple lifestyle choices. While extensive efforts have been made in recent decades to improve these risk factors; many of these efforts have not been successful. This lack of successful behavior change can be attributed in part to societal barriers discouraging healthy behavior.
- **Risk Factors for CVD**

Preventable Risk Factors: Type-2 Diabetes; High Blood Cholesterol; High Blood Pressure; Lack of Physical Activity; Overweight and Obesity; Unhealthy Eating; Smoking;

Non-Preventable Risk Factors: Increasing Age; Male gender; Race/Ethnicity; Family History of Premature CVD
- Large disparities in heart disease mortality exist between different racial and ethnic groups in Nebraska, making race an important non-preventable risk factor for heart disease.

Tobacco Use: Annually, another 46,700 Nebraskans are suffering from smoking attributable diseases[1]. Smoking-related health care costs total $592 million annually in Nebraska (including $134 million in Medicaid expenditures). The annual cost of smoking related lost productivity in Nebraska is $506 million[2]. In addition, the use of smokeless tobacco is related to a higher risk of developing oral cancers, ulcers and heart disease.

- Despite the known adverse health effects of tobacco use, cigarette smoking is still prevalent in Nebraska. In 2011, the Nebraska Behavioral Risk Factor Surveillance System (BRFSS) found that 20% of the adult population (age 18 and older) smoked. Twenty-four percent (24%) were former smokers and 56% had never smoked. Among the current smokers, 75% smoked cigarettes every day, while 25% smoked only on some days. Based on the prevalence rate and adult population, it is estimated that approximately 276,000 adults in Nebraska are current cigarette smokers in 2011.

Target Population:
Number: 4,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 1,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: Yes
Location: Entire state
Target and Disparate Data Sources: BRFSS, YRBS, Snack and Go Evaluation Tool, NDHHS Epidemeiology and Informatics Unit: Chronic Disease Status Report

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: National Prevention Strategy June 2011
CDC Recommended Community Strategies and Measurement to Prevent Obesity
IOM Local Government Actions to Prevent Childhood Obesity

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $310,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $150,000
Funds to Local Entities: $310,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
75-99% - Primary source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Community Based Prevention Projects
Between 10/2014 and 09/2015, the Health Promotion Unit staff and subgrantees will implement **10** Community-based Prevention Projects focusing on selected chronic disease and injury prevention interventions.

Annual Activities:
1. Issue RFA
Between 10/2014 and 09/2015, develop and issue an RFA to invite external entities, including local health departments, tribal health departments, and other non-profit agencies to apply for funds to carry out specified projects

2. Select Subgrantees
Between 10/2014 and 09/2015, review and score applications

3. Monitor progress of subgrantees
Between 10/2014 and 09/2015, appoint staff to provide technical assistance, conduct site visits, review reports and report back to oversight group

Objective 2:
Increase access to healthy foods and beverages
Between 10/2014 and 09/2015, DHHS Staff, subgrantees and/or contractors will increase the number of small retail venues within selected communities that sell healthier food options in underserved areas from 4 to **8**.

Annual Activities:
1. Expansion of Snack and Go Healthy Food Retail Project
Between 10/2014 and 09/2015, make the necessary contacts to expand the "Snack & Go" project.

- The existing project is a community intervention designed for conveniences stores located near a middle or high school to promote healthier snack options in highly visible locations within their store. Modeled after research-tested interventions, Snack & Go involves conducting a pre-assessment of the store inventory, product placement, and promotion. Participating stores are then provided a Standard Kit of promotional materials and must agree to selecting 2 sites within their store for Snack & Go products. A community coordinator works with the participating store manager to select the products for the two locations. A post-assessment is completed at 6 months to determine if the products continue to meet the nutrition brand guidelines and to capture intervention outcomes.
- Snack & Go nutrition brand guidelines align with the United States Department of Agriculture's Smarter Snack Guidelines, which will be implemented in schools during the 2013-2014 school year.
- Counties targeted for the expansion are: Cass, Douglas, Lancaster and Sarpy.

National Health Objective: HO PHI-7 National Data for Healthy People 2020 Objectives

State Health Objective(s):
Between 10/2013 and 09/2018, **maintain at least one comprehensive state-level health data surveillance system and sustain the capacity for collection and analysis of needed health data on all populations for use in development of health status indicators.**

Baseline:
6 major health databases are maintained and reports are issued. Information is provided to at least ten types of end users (decision makers, health planners, health program staff, medical and health professionals, community coalitions, and the public).

Data Source:
NDHHS, Health Licensure & Date Section, Epidemiology and Informatics Unit

State Health Problem:

Health Burden:
The rationale for investing PHHSBG funds in data collection, analysis and distribution includes the following elements:

1. Surveillance, epidemiology and evaluation are prime public health functions of any state health agency.
Governor Heineman wants the NDHHS to be the leading source of reliable data and health information in Nebraska, which will strengthen programs that address the state's most challenging health issues. In addition, one of the top five priorities for NDHHS Division of Public Health is to become the trusted source of state health data. PHHSBG funds are invested in data systems development and maintenance in order to realize those purposes.

2. No other state agency, university or private entity has access to the full range of health data or the expertise to analyze and share the information with state and local programs that are addressing the critical health concerns in Nebraska.

Therefore, the NDHHS must collect and analyze data in order to increase knowledge of reported health behaviors, track achievement of objectives, evaluate the success of interventions and complete reporting for the PHHS Block Grant. It is logical that a portion of Nebraska's PHHS Block Grant funds be used to support the data system.

"The third component of infrastructure development is information and data resources. Accurate and timely data must be available to conduct community and statewide needs assessments as well as provide a basis for formulating health policies and appropriate intervention strategies. Greater efforts are needed to link databases together and make data more accessible for people at the local level. Greater efforts should also be made to collect and analyze new data that will more clearly identify health needs."
[Source: *Turning Point: Nebraska's Plan to Strengthen and Transform Public Health in Our State, 1999]*

3. Every funded program is required base decisions about interventions upon reliable health data, which is supplied by the Epidemiology and Informatics Unit of NDHHS.

4. Many sources of federal funding are being organized according to the Chronic Disease Domains. Programs within the NDHHS are striving to work collaboratively across programs and organizational structures.

Domain 1: Epidemiology and Surveillance: Gather, analyze, and disseminate data and information and conduct evaluation to inform, prioritize, deliver, and monitor programs and population health.
Making the investment in epidemiology and surveillance provides states with the necessary expertise to collect data and information and to develop and deploy effective interventions, identify and address gaps in program delivery, and monitor and evaluate progress in achieving program goals. Data and information come with the responsibility to use it routinely to inform decision makers and the public regarding the effectiveness of preventive interventions and the burden of chronic diseases and their associated risk factors, public health impact, and program effectiveness. The need to publicize widely the results of states' work in public health and demonstrate to the American people the return on their investment in prevention has never been greater.
Examples of Activities
• Collect appropriate data to monitor risk factors and chronic conditions of interest through surveillance systems (such as the BRFSS, NPCR and other cancer screening data systems, Vital Statistics, and Medicare data sets), rapidly develop and disseminate data reports in easy-to-use and understand formats, describe multiple chronic conditions, and use data to drive state and local public health action.
• Conduct surveillance of behavioral risk factors, social determinants of health, and monitor environmental change policies related to healthful nutrition, physical activity, tobacco, community water fluoridation, and

other areas.
• Collect cancer surveillance data to assess cancer burden and trends, identify high risk populations, and guide planning and evaluation of cancer control programs (e.g., prevention, screening and treatment efforts).
• Conduct youth and adult surveillance of tobacco-related knowledge, attitudes and behaviors (ATS/NATS, YTS/NYTS); translate and disseminate data and information for action.

5. The NDHHS is preparing for accreditation and the data surveillance and epidemiology functions partially supported by the PHHSBG assist in that preparation.

Target Population:
Number: 7,000
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions

Disparate Population:
Number: 40
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: BRFSS: The guideline for completing BRFSS surveys was developed by CDC - Behavioral Surveillance Branch, called the Behavioral Risk Factor Surveillance System Operational and User's Guide.

Health Data: Toward a Health Statistics System for the 21st Century: Summary of a Workshop. http://www.nap.edu/openbook/0309075823/html, copyright, 2000 The National Academy of Sciences.

The Future of the Public's Health in the 21st Century (2002). http://www.nap.edu/openbook/030908704X/html/96.html, copyright 2002, 2001 The National Academy of Sciences.

CHD Unit: The Future of Public Health and The Future of the Public's Health in the 21st Century (Institute of Medicine of the National Academies)

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $38,700
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Data and Surveillance
Between 10/2013 and 09/2014, NDHHS staff will provide health data to **5,000** users of data.

Annual Activities:

1. Data Collection and Analysis

Between 10/2013 and 09/2014, Identify all relevant health indicators for local health department reporting, update and execute analysis program, populate a multi-sheet spreadsheet with current data for these indicators for use by local health departments, generate and disseminate reports electronically.

The expected outcomes of this work include: (1) enhanced and ongoing availability of data that local health departments rely upon; (2) moving the Department toward the goal of being the trusted source of health data; (3) support applications for public health accreditation at the state and local levels.

2. Nebraska HP2020 Basic Report

Between 10/2013 and 09/2014, Review US HP2020 objectives and latest trends. Analyze Nebraska data for selected HP2020 objectives and prepare report of objectives and current rates and trends.

National Health Objective: HO PHI-13 Epidemiology Services

State Health Objective(s):

Between 10/2013 and 09/2018, enhance the epidemiology and health informatics capacity of the NDHHS by: (1) maintaining the functions of the one existing the **Nebraska Joint Public Health Data Center**, and (2) acquiring a specifically-qualified **Public Health Informatician** on staff.

Baseline:

(1) Nebraska Joint Public Health Data Center (JDC)

The JDC was established collaboratively in 2011 by the Nebraska Department of Health and Human Services (NDHHS) and the College of Public Health at the University of Nebraska Medical Center (UNMC). Its mission is to improve public health practice and research by enhancing data quality, utilization and integration.

During the past four years, the JNC has updated a comprehensive public health data inventory, performed data linkages, established a master data index, developed and implemented query system, conducted studies, assisted in internal trainings to improve epidemiology and statistics competencies of NDHHS staff, and provided technical assistance in data linkages and analyses.
The JNC has an Advisory Board that includes members from DHHS and UNMC. The Board provides guidance on the overall direction of the Joint Public Health Data Center, input and feedback on future projects, and promotes the dissemination of data and information.

The JNC was funded by the CDC Public Health Infrastructure grant. That funding will end in September 2014.

(2) Public Health Informatician

Public Health Informatics is the systematic application of information and technology to public health practice, research and training. It advances the state of information science and application of information technologies to aid in the detection and management of diseases in individuals and populations.

A Public Health Informatician is an individual whose expertise is connecting the world of epidemiological needs to the development of useful information technology solutions.

Data Source:
The major data source is the Nebraska Department of Health and Human Services, the rest of the data are from other state agencies such as the Departments of Roads, Department of Motor Vehicles, Department of Education, in addition to non-governmental agencies such as the Nebraska Hospital Association.

http://dhhs.ne.gov/publichealth/DataCenter/Pages/DataCenterHome.aspx

State Health Problem:

Health Burden:
(1)The Nebraska Joint Public Health Data Center (JNC) has been supported by the CDC Infrastructure Grant. Due to the unavailability of fifth year funding (2014 to 2015), all critical functions and projects related to public health data integration and utilization are jeopardized. The loss of the JNC would create a huge impact on the availability of data to plan, implement, and evaluate public health programs, surveillance activities, and research projects at national, state, and local levels.

(2) The lack of a dedicated Public Health Informatician limits the ability of the NDHHS, Division of Public Health to respond to current and trending need created by the development of different ways of delivering public health and health care services and newer technologies and communications channels.

Target Population:
Number: 400
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Safety Organizations, Other

Disparate Population:
Number: 400
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers, Disease Surveillance - High Risk, Community Based Organizations, Health Care Systems, Research and Educational Institutions, Safety Organizations, Other

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)

Other: Principles and Practices of Public Health Surveillance (3rd Edition)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $277,200
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Enhance public health informatics capacity
Between 10/2014 and 09/2015, DHHS Epidemiology and Informatics Unit lead staff will increase the number of DHHS public health informaticians from 0 to **1**.

Annual Activities:
1. Recruit and train the informatician
Between 10/2014 and 09/2015, Working with DHHS Human Resources, the Epidemiology and Informatics Unit lead staff will recruit and train the new hire.

2. Develop Nebraska Public Health Informatics Strategic Plan
Between 10/2014 and 09/2015, the informatician is responsible for developing the Nebraska Public Health informatics strategic plan, in cooperation with related staff.

3. Coordinate public health informatics activities
Between 10/2014 and 09/2015, the informatician is responsible for coordinating all activities of public health informatics programs at Division of Public Health

Objective 2:
Maintain the Nebraska Joint Public Health Data Center
Between 10/2014 and 09/2015, staff of UNMC College of Public Health in collaboration with the staff of DHHS Surveillance and Informatics Unit will maintain **1** Joint Public Health Data Center.

Annual Activities:
1. Refill vacant position and train the data analyst
Between 10/2014 and 09/2015, utilize UNMC Human Resources System to recuit and hire qualified candidate
Data Center directors will provide trainings to the new hire.

2. Update Data Inventory
Between 10/2014 and 09/2015, data analyst will update the existing data inventory with assistance of staff related to the Nebraska Joint Public Health Data Center.

3. Perform data linkages
Between 10/2014 and 09/2015, continue to conduct routine data linkages, such as Cancer Registry to Death Certificate and Hospital Discharge Data.

4. Develop Master Person Index
Between 10/2014 and 09/2015, continue to develop "Public Health Master Person Index" based on routine collected individual data sets.

5. Conduct selected studies
Between 10/2014 and 09/2015, conduct selected studies based on integrated data per request from DHHS programs .

National Health Objective: HO PHI-15 Health Improvement Plans

State Health Objective(s):

Between 10/2013 and 09/2018, **Increase the proportion of state and local public health agencies that have implemented a health improvement plan.**

Baseline:
A state health improvement plan was completed in 2013 for the Nebraska Division of Public Health. 18 local health departments have completed or are in the process of completing a health improvement plan.

Data Source:
Nebraska Department of Health and Human Services (NDHHS)

State Health Problem:

Health Burden:
State and local health improvement plans help improve the health of a population by bringing together partners to focus public health strategies and efforts resulting in wider impact. The Nebraska State health improvement plan was created in collaboration with public health partners from across the state. All partners are required to play key roles in the implementation. The Nebraska Division of Public Health will use PHHSBG funds to work with local health departments to implement evidence-based strategies from the State health improvement plan and to prepare for accreditation; and to support training related to core public health competencies outlined in the plan. The NDHHS is preparing for accreditation that requires evidence of systematic planning and the development of health improvement plans partially supported by the PHHSBG.
The following assumptions are made regarding is Health Objective:
1. That improving the ability of NDHHS programs to carry out the core functions of public health will improve the health status of all Nebraska residents and narrow the disparity in health status between minority and majority populations.
2. That improving the capacity of Nebraska's local/district health departments to carry out the 3 Core Functions and 10 Essential Services of Public Health requires developing performance standards, training the public health workforce and facilitating health improvement planning.
3. That conducting surveys and gathering health-related data, analyzing survey findings and health data trends, and reporting reports and setting goals will help guide the rational development of health interventions to protect health and safety of all.
4. That carrying out coordination and monitoring of funded programs will improve program quality and increase their adherence to sound principles of public health, including use of science-based strategic planning, implementation of evidence based interventions, establishment of performance measures and tracking of impacts and outcomes of programs.

Target Population:
Number: 19
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Disparate Population:
Number: 19
Infrastructure Groups: State and Local Health Departments, Boards, Coalitions, Task Forces, Community Planning, Policy Makers

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The Future of Public Health (Institute of Medicine), 1988.

The Future of the Public's Health in the 21st Century (National Institutes of Health) 2003.

Building Our Nation's Public Health Systems: Using performance standards to improve public health

practice (American Public Health Association, Association of State and Territorial Health Officials, National Association of County and City Health Officials, National Association of Local Boards of Health National Network of Public health Institutes, Public Health Foundation, Centers for Disease Control and Prevention) November 2005.

Operational Definition of a Functional Local Health Department, as listed in Model Practices, (National Association of City and County Health Officials) November 2005.

Final Recommendations for a Voluntary National Accreditation Program for State and Local Public Health Departments (Association of State and Territorial Health Officials and National Association of County and City Health Officials with funding from the Centers for Disease Control and Prevention and the Robert Woods Johnson Foundation) September 12, 2006.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $599,500
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $150,000
Funds to Local Entities: $100,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Implementation of State Health Improvement Plan Activities
Between 10/2014 and 09/2015, State health improvement plan coalition members and partners will implement **5** key strategies from the State health improvement plan.

Annual Activities:
1. Provide support to coalition members and partners
Between 10/2014 and 09/2015, NDHHS staff will provide funding and support to coalition members and partners to implement key strategies from the State health improvement plan (e.g., initial assessments and data analysis).

Objective 2:
State Level Oversight
Between 10/2014 and 09/2015, PHHS Block Grant Coordinator will evaluate **16** projects or programs funded with PHHS Block Grant dollars, monitoring progress in achieving State Health Objectives, Impact Objectives and Activities as described in Nebraska's application to CDC.

Annual Activities:
1. Monitor and Support
Between 10/2014 and 09/2015, the PHHS Block Grant Coordinator will monitor subaward performance, review written reports, hold one-on-one meetings and telephone contacts, participate in group telephone consultation, meet with program staff members on location, conduct technical assistance and training, and attend funded activities to observe progress.

Objective 3:
Support for Local Health Departments

Between 10/2014 and 09/2015, NDHHS staff, contractors, and local health department staff members will provide technical assistance, funding, and training opportunities related to health improvement plan implementation and accreditation preparation to **18** local health departments and their key partners.

Annual Activities:

1. Technical Assistance

Between 10/2014 and 09/2015, NDHHS staff will assess the technical assistance needs of local health departments. Staff members will gather models and standards including evidence-based program and accreditation information to share with local health departments. NDHHS staff will also plan and arrange technical assistance and training opportunities. Technical assistance will be provided in the form of monitoring progress reports, one-on-one mentoring, conducting site visits, coordinating group update and sharing conference calls.

2. Financial Assistance

Between 10/2014 and 09/2015, NDHHS will provide funds for local health departments to implement evidence-based strategies outlined in the state and local health improvement plans. PHHSBG funds are used to leverage funds from state and other federally funded programs, pooled to provide financial assistance of this type to local health departments. Approximately up to eight awards will be made to local health departments.

Objective 4:

Training and Educational Resources

Between 10/2014 and 09/2015, NDHHS staff and contractors will provide training on relevant topics related to core public health competencies, based on perceived need, to **19** state (1) and local health departments (18).

Annual Activities:

1. Training Sessions

Between 10/2014 and 09/2015, NDHHS staff members will coordinate training opportunities for local health department staff by identifying resources (e.g., presenters, materials), arranging locations and presenters, marketing the training sessions, and arranging the registration and evaluation processes. Staff will also coordinate training opportunities for Division of Public Health staff based on the workforce development plan.

2. Mentoring

Between 10/2014 and 09/2015, NDHHS staff will provide one-on-one mentoring to local health department staff members to increase their capacity to implement evidence-based programs and prepare for accreditation including planning, assessment, and quality improvement.

National Health Objective: HO PHI-17 Accredited Public Health Agencies

State Health Objective(s):

Between 10/2013 and 09/2018, Increase the proportion of state public health agencies that are accredited in Nebraska.

Baseline:

Currently the state public health agency in not accredited.

Data Source:

Public Health Accreditation Board

State Health Problem:

Health Burden:

Public health department accreditation is necessary to improve the quality and accountability of public

health departments across the nation. Currently in Nebraska, the state health department is not accredited.

Target Population:
Number: 1
Infrastructure Groups: State and Local Health Departments

Disparate Population:
Number: 1
Infrastructure Groups: State and Local Health Departments

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: The Centers for Disease Control and Prevention in partnership with several other national public health organizations is supporting the implementation of a national voluntary accreditation program for state, local, tribal, and territorial health departments.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $47,700
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $0
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Apply for public health accreditation
Between 10/2014 and 09/2015, The Office of Community and Rural Health will increase the number of applications submitted to the Public Health Accreditation Board for the Nebraska Division of Public Health from 0 to **1**.

Annual Activities:
1. Submit application to Public Health Accreditation Board
Between 10/2014 and 09/2015, The Office will submit an application and fee to the Public Health Accreditation Board which will initiate the accreditation process for the Division of Public Health.

2. Submit documentation to the Public Health Accreditation Board
Between 10/2014 and 09/2015, The Office will upload all required documentation into E-PHAB and submit to the Public Health Accreditation Board.

State Program Title: UNINTENTIONAL AND INTENTIONAL INJURY PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Unintentional and Intentional Injury Prevention Program*** is dedicated to the prevention of unintentional and intentional injuries, injury-related hospitalizations, long-term disability and deaths.

Health Priorities:

Focus on prevention of traumatic brain injury in youth, consistent child restraint use among children up to 10 years, reduction of fall among older adults. The basis for establishment of these focus areas is listed below:

- Injuries are the fifth leading causes of death for Nebraskans.
- For Nebraskans age 1 through 44 years, unintentional injuries are the leading cause of death.
- In Nebraska, more years of potential life are lost due to injury than any other cause of death.
- Falls are the leading cause of injury hospital discharge for all ages combined in Nebraska. Falls are also the second leading cause of unintentional injury death in Nebraska.
- Statewide, the leading cause of injury death is motor vehicle crashes, followed by suicide.
- Eight percent of respondents to the Youth Risk Behavior Survey reported that someone forced them to have sex when they did not want to.

Primary Strategic Partnerships:

Unintentional Injury:

External: Safe Kids Coalitions and Chapters, Child Passenger Safety Technicians and Instructors, Local Public Health Departments, Nebraska Office of Highway Safety, Nebraska Safety Council, local hospitals, Nebraska State Patrol, Brain Injury Association of Nebraska, Nebraska Athletic Trainer's Association, parents and the general public.

Internal: NDHHS programs which include: Epidemiology and Informatics Unit (CODES Crash Outcome Data Evaluation System); Nutrition and Physical Activity for Health; Community and Rural Health Planning Unit, EMS/Trauma System; Lifespan Health Services Unit, Maternal and Child Health, Public Health/Child Care Licensing, Child and Family Services.

Intentional Injury:

Sex Offense Set-Aside funds are contracted through the NDHHS Injury Prevention and Control Program to the Nebraska Domestic Violence Sexual Assault Coalition. The Coalition provides technical assistance to 19 sexual assault/crisis centers across the state.

Suicide: Nebraska Suicide Prevention Coalition, LOSS (Local Outreach to Suicide Survivors) Team, University of Nebraska Public Policy Center, Nebraska Interchurch Ministries, Bryan Health Systems, NDHHS Behavioral Health and Lifespan Health.

Evaluation Methodology:

Unintentional Injury: Collection and monitoring of reports from Safe Kids Coalitions and Chapters, and Child Passenger Technicians and other entities receiving contracts and subawards. Access Death Data and Hospital Discharge Data, analyze results and trends. Provide data results to partner programs. Monitor program participant survey results.

Intentional Injury:
Rape Set-Aside: Data from Youth Risk Behavior Survey. Collection and analysis of reports from Coalition on evaluation of social media campaign, including website hits and materials distributed.
Suicide: Access Death Data, Hospital Discharge Data, and Child Death Review Team data, analyze results and trends.
Source: NDHHS Vital Statistics, NDHHS Hospital Discharge Data, Nebraska Domestic Violence Sexual Assault Coalition.

State Program Setting:

Business, corporation or industry, Child care center, Community based organization, Home, Local health department, Medical or clinical site, Parks or playgrounds, Rape crisis center, Schools or school district, Senior residence or center, State health department, University or college, Work site

FTEs (Full Time Equivalents):

Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Position Title: Community Health Educator Senior
State-Level: 85% Local: 0% Other: 0% Total: 85%

Total Number of Positions Funded: 1
Total FTEs Funded: 0.85

National Health Objective: HO IVP-2 Traumatic Brain Injury

State Health Objective(s):

Between 10/2013 and 09/2018,

- For children aged 1 to 14 years, reduce the number of traumatic brain injuries needing emergency department visits to less than 539 per 100,000 Nebraska children.
- For children aged 1 to 14 years, reduce the number of traumatic brain injuries needing hospitalizations to less than 28 per 100,000 Nebraska children.

Baseline:

- In 2011, there were 580 per 100,000 children (ages 1 to 14 years) in Nebraska requiring emergency room care for traumatic brain injury. Compared to the 2004-2008 baseline rate (539 per 100,000), the 2011 rate of emergency room care due to traumatic brain injury has increased for children in Nebraska.

- In 2011, there were 24 per 100,000 children (ages 1 to 14 years) in Nebraska hospitalized due to traumatic brain injury. Compared to the 2004-2008 baseline rate (28 per 100,000), the 2011 rate of hospitalization due to traumatic brain injury has decreased slightly for children in Nebraska.

Data Source:
Nebraska Hospital Discharge Data 2004-2008 (baseline)
Nebraska Hospital Discharge Data, 2011

State Health Problem:

Health Burden:
The leading causes of TBI in Nebraska are motor vehicle crashes and falls. Conducting TBI prevention programming that addresses these causes of TBI is an important need in Nebraska. In 2012, approximately $60,000 of PHHS Block Grant funds were used to address TBI related causes. NDHHS

partners with the Brain Injury Association of Nebraska and the Nebraska Office of Highway Safety to address the causes of TBI.

From 2004 to 2008, 1,610 Nebraskans died as a result of a traumatic brain injury, and such deaths were more common among males than among females. In addition, there were 4,750 hospitalizations and 30,265 emergency department (ED) visits for TBI. Average TBI emergency medical costs are $1,663.56 (median) per emergency room visit and $17,151.99 (median) per hospitalization.

Nebraska Hospital Discharge Data, 2011
Traumatic Brain Injury in Nebraska 2004-2008 Report, 2011

Target Population:
Number: 188,238
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 188,238
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: NDHHS Vital Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:
Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
National Guideline Clearinghouse (Agency for Healthcare Research and Quality)
Promising Practices Network (RAND Corporation)

Funds Allocated and Block Grant Role in Addressing this Health Objective:
Total Current Year Funds Allocated to Health Objective: $82,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $0
Funds to Local Entities: $10,000
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:

Bicycle Safety/Home Safety

Between 10/2013 and 09/2014, NDHHS Injury Prevention and Control Program will provide sub grants to **at least 4** local Safe Kids coalitions to conduct injury prevention programming to reduce traumatic brain injuries in children and youth from bicycle crashes and falls in the home.

Annual Activities:

1. Home Safety and Bicycle Safety Grants

Between 10/2013 and 09/2014,

- Develop an application and process to determine which local Safe Kids programs will receive funding.
- Provide funding to local Safe Kids programs to administer bicycle and/or home safety injury prevention programming.
- Provide technical assistance to grantees about evidence based interventions in the areas of home and bicycle safety.
- Where applicable conduct evaluation to determine reach and behavior change as a result of the Safe Kid's injury prevention programs that are funded.

Objective 2:

Concussion/TBI awareness and prevention

Between 10/2013 and 09/2014, NDHHS Injury Prevention Program and Brain Injury Association of Nebraska will develop **1** statewide concussion coalition to provide and guide concussion education, awareness and prevention across the state.

Annual Activities:

1. Establish Statewide Concussion Coalition

Between 10/2013 and 09/2014, Partner with the Brain Injury Association of Nebraska to establish a Concussion Coalition to provide and guide concussion education, awareness and prevention across the state. Focus areas of the Coalition may include return to learn, community sports, and healthcare provider education. Other partners will include local/district health departments, local Safe Kids programs, Nebraska State Athletic Trainers Association, Nebraska School Activities Association, YMCA, the Nebraska Medical Association, and other community partners such as hospitals.

National Health Objective: HO IVP-16 Age-Appropriate Child Restraint Use

State Health Objective(s):

Between 10/2013 and 09/2018, increase observed use of child restraints to 98 percent.

Baseline:

Since inception of the child restraint usage survey, observed usage has risen from 56 percent (1999) to 95.9 percent (2012).

Data Source:

Nebraska Office of Highway Safety - NDOR

- Child Restraint Surveys are conducted each year between August and September.
- Child safety seat use is surveyed annually through observations conducted in rural and urban counties in Nebraska.

State Health Problem:

Health Burden:

In Nebraska, for children ages 1-19 years, the leading cause of death is motor vehicle or traffic crashes (CDC WISQARS, 2001 - 2010). Nebraska's child safety seat law only requires children up to age six to use child safety seats (including booster seats) while riding in vehicles. Best practice guidelines provided

by the National Highway Traffic Safety Administration recommend children use booster seats until the child reaches a height of 57 inches or to about the age of 10. Since Nebraska's law does not follow best practice guidelines, it is important to educate parents and care givers about proper child safety seat use and the importance of using booster seats in older children.

In 2012, Safe Kids Nebraska funded 14 car seat safety checks and these events found a 72 percent misuse rate. According to Safe Kids Worldwide Safe Kids Worldwide website, 2013):
- Children seated in a booster seat in the back seat of the car are 45 percent less likely to be injured in a crash than children using a seat belt alone.
- Children 2 to 5 years of age using safety belts prematurely are four times more likely to suffer a serious head injury in a crash than those restrained in child safety seats or booster seats.
- When installed and used correctly, child safety seats and safety belts can prevent injuries and save lives. Child safety seats can reduce fatal injury by up to 71 percent for infants and 54 percent for toddlers (ages 1 to 4).
- The overall critical misuse for child restraints is about 73 percent. Infant seats have the highest percent of critical misuse, followed by rear- facing convertible seats.

Target Population:
Number: 188,238
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 188,238
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: NDHHS Vital Statistics

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Best Practice Initiative (U.S. Department of Health and Human Service)
Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
MMWR Recommendations and Reports (Centers for Disease Control and Prevention)
Model Practices Database (National Association of County and City Health Officials)
Promising Practices Network (RAND Corporation)

Other: Governor's Highway Safety Association's Occupant Protection for Children: Best Practices Manual, Model Program Elements Section to address childhood occupant protection: 2007

Safe Kids World Wide: Motor Vehicle occupant injury fact sheet (2004).

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $62,000
Total Prior Year Funds Allocated to Health Objective: $0

Funds Allocated to Disparate Populations: $20,000
Funds to Local Entities: $6,500
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Child Passenger Safety Programs
Between 10/2013 and 09/2014, NDHHS Injury Prevention Program, partners and contractors will increase the rate of observed use of child restraints from 96 percent to **97 percent**.

Annual Activities:
1. Child Passenger Safety Training
Between 10/2013 and 09/2014,
- Conduct four National Highway Traffic Safety Administration child passenger trainings (contingent upon outside funding).
- Conduct meetings with the Nebraska Child Passenger Safety Advisory Committee to establish a training schedule.
- Implement/coordinate/evaluate Safe Kids Nebraska Child Care Transportation Training in accordance with new NDHHS Child care regulations.
- Curriculum development and implementation of the Safe Kids Nebraska Child Passenger Safety Transportation Training to the DHHS Child and Family Services workers who transport children.

2. Technical Assistance
Between 10/2013 and 09/2014,
- Provide technical assistance to Child Passenger Safety Technicians conducting child passenger advocacy trainings to communities across the state.
- Provide technical support to over 350 Child Passenger Safety Technicians through newsletters, e-mail lists, mailings, technical updates and grant funding.
- Provide a minimum of 10 mini-grants to local technicians to conduct child passenger safety seat checks in their communities.
- Provide technical assistance to the child passenger safety technicians who are conducting the child passenger safety trainings to the NDHHS Child and family service workers across the state.

3. Coordinate Safe Kids Nebraska Child Care Transportation Training
Between 10/2013 and 09/2014,
- Update the Safe Kids Nebraska Child Care Transportation Training to reflect updates in child passenger safety best practices and issues associated with child care providers who are not transporting child consistent with best practices.
- Provide technical assistance to Child Passenger Safety technicians who conduct the Safe Kids Nebraska Child Care Transportation Training.
- Provide technical assistance to child care providers related to the child passenger safety to improve their transportation practices.

Objective 2:
Public Education and Support
Between 10/2013 and 09/2014, NDHHS Injury Prevention Program and partners will provide information and technical assistance in response to requests for best practice child passenger safety programming

and effective evaluation methods to **150** Child Passenger Safety Technicians, local public health departments, child care providers and Safe Kids coalitions.

Annual Activities:

1. Public Information

Between 10/2013 and 09/2014,

- Respond to calls from the public, school districts, hospitals or public health departments on questions about child safety seat use and restraint laws on a continuous basis.
- Participate in Child Passenger Safety Week in producing press releases and promoting the national theme to Safe Kids coalitions, general public, hospitals, public health departments and technicians.
- Provide child care centers across Nebraska with information about the Safe Kids Nebraska Child care transportation training and other child passenger safety issues.
- Provide technical assistant to the DHHS child and family services trainers providing the Safe Kids Nebraska Child Passenger Safety training.

National Health Objective: HO IVP-23 Deaths from Falls

State Health Objective(s):

Between 10/2013 and 09/2018, Reduce the age adjusted death and injury rates from falls to:

- Less than 7.7 deaths per 100,000 Nebraskans.
- Less than 226.5 hospitalizations per 100,000 Nebraskans.
- Less than 1,859 emergency department (ED) visits per 100,000 Nebraskans.

Baseline:

Falls are the most common non-fatal injury in Nebraska.
In Nebraska (2011):

- Falls in all age groups accounted for more than 5,000 hospitalizations (an age-adjusted rate of 237.2 per 100,000 population) and over 39,000 emergency department visits (an age-adjusted rate of 2,063 per 100,000).
- Falls were the second leading cause of unintentional injury death for all age groups, with unintentional falls resulting in 173 deaths (an age-adjusted rate of 7.8 per 100,000 population).
- Falls were the leading cause of injury death for adults in Nebraska age 65 years and older.

The death rate due to unintentional falls for all age groups has remained stable for the past ten years.

Data Source:

Nebraska death certificates
Nebraska hospital discharge data
Nebraska Vital Statistics Report, 2011

State Health Problem:

Health Burden:

In the United States:

- One out of three older adults (those aged 65 or older) falls each year.
- Among older adults, falls are the leading cause of both fatal and nonfatal injuries.
- In 2010, 2.3 million nonfatal fall injuries among older adults were treated in emergency departments and more than 662,000 of these patients were hospitalized.
- In 2010, the direct medical costs of falls, adjusted for inflation, was $30 billion

(CDC)

Target Population:
Number: 500,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 500,000
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: Under 1 year, 1 - 3 years, 4 - 11 years, 12 - 19 years, 50 - 64 years, 65 years and older
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: NE Vital Statistics 2007, Hospital Discharge Data 2007

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Clinical Preventive Services (U.S. Preventive Services Task Force)
Guide to Community Preventive Services (Task Force on Community Preventive Services)
Model Practices Database (National Association of County and City Health Officials)
Promising Practices Network (RAND Corporation)

Other: CDC- Preventing Falls: What Works

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $101,000
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $30,000
Funds to Local Entities: $36,000
Role of Block Grant Dollars: No other existing federal or state funds
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
100% - Total source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Older Adult Fall Prevention
Between 10/2013 and 09/2014, NDHHS Injury Prevention Program and contractors will establish **4** Tai Chi programs based in local public health departments which are implemented in local communities.

Annual Activities:
1. Program Development and Maintenance
Between 10/2013 and 09/2014,
- Provide public health departments and community partners training and resources to conduct Tai Chi classes in their communities.

- Implement evaluation to measure the effectiveness of the Tai Chi program through formative or process evaluation.
- Collaborate with state agencies and local health departments on reducing older adult falls.

Objective 2:
Older Adult Falls
Between 10/2013 and 09/2014, NDHHS Injury Prevention Program, partners and contractors will implement **1** evidence-based program, including Tai Chi, to address the problem of older adult falls in Nebraska.

Annual Activities:
1. Older Adult Falls Coalition Meetings
Between 10/2013 and 09/2014, Provide education on the scope of the problem of older adult falls in Nebraska and evidence-based prevention strategies to public health partners and other community partners through Falls Coalition activities.

2. Older Adult Falls Prevention Day
Between 10/2013 and 09/2014, Provide education on older adult falls prevention by participating in the National Older Adult Falls Prevention Day (activities include local community events, distribution of materials, and media releases).

Objective 3:
Stepping On
Between 10/2014 and 09/2015, NDHHS Injury Prevention and Control Program staff will establish **5** sites that will implement the evidence-based fall prevention program, Stepping On.

Annual Activities:
1. Development of Stepping On Program
Between 10/2014 and 09/2015, Identify Stepping On trainers; schedule training sessions.
Develop application for sites/partners to implement at the local level. Select sites and develop subaward agreements. Facilitate training sessions for local sites.
Provide technical assistance to implementation sites. Conduct evaluation as per program guidelines.

Objective 4:
Tai Chi Training
Between 10/2013 and 09/2014, NDHHS Injury Prevention Program will provide Tai Chi instructor training and Tai Chi instructor update training to **50** community Tai Chi instructors.

Annual Activities:
1. Tai Chi Instructor Training
Between 10/2013 and 09/2014, conduct Tai Chi training and Tai Chi update training for new and current Tai Chi instructors.

2. Tai Chi Instructor Development
Between 10/2013 and 09/2014, enhance Tai Chi instructor development through the use of technical assistance and site visits provided by a Tai Chi consultant.

National Health Objective: HO IVP-40 Sexual Violence (Rape Prevention)

State Health Objective(s):

Between 10/2013 and 09/2018, The percent of total respondents on the Youth Risk Behavior Survey who report that they were forced to have sex when they did not want to will decrease from 8% to 7% . The Nebraska Domestic Violence Sexual Assault Coalition (NDVSAC) will continue to use the YRBS as

its primary data source for this objective. The YRBS is a random sample survey that targets public high school students, grades 9 – 12, in Nebraska. It is the only state level source of information on sexual violence among Nebraska high school students. 2011 marks the eleventh administration of the YRBS. The Nebraska Departments of Education and Health and Human Services administers the survey in the fall of even calendar years and releases the findings the following year. The 2011 YRBS had an overall response rate of 66%. Thus, for the first time since 2005, the CDC was able to weight the data to be representative of all public high school students in Nebraska.

The NDVSAC will also use the National Intimate Partner and Sexual Violence Survey (NISVS) to inform its efforts towards this objective. The Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control launched the NISVS in 2010 with the support of the National Institute of Justice and the Department of Defense. The survey is an ongoing, nationally representative telephone survey that collects information about sexual and intimate partner violence and stalking among women and men aged 18 or older in the United States. While respondents are older than the 11 – 17 target age ranges for this particular objective, the survey asks respondents about their experiences with violence throughout their lifetime, including childhood. The CDC breaks down the data by state.

Baseline:

8 percent of the 3,832 YRBS respondents reported that someone forced them to have sex when they did not want to. (2011)
Of the 2,885 respondents grades 9-12, 9.9% (N = 286) of the total indicated that they were forced to have sex when they did not want to (2009).

Data Source:

Youth Risk Behavior Survey (2011), unweighted
Youth Risk Behavior Survey (2009), unweighted

State Health Problem:

Health Burden:
According to the NISVS, nearly 1 in 5 women and 1 in 71 men in the United States have been raped in their lifetimes (CDC, 2011). About 1 in 2 women and 1 in 5 men have experienced some other form of sexual violence sometime in their lives. The lifetime prevalence of sexual violence for men and women in Nebraska mirrors these proportions, although the exact prevalence of rape and sexual violence is slightly higher among Nebraskans. Ultimately, approximately 129,000 women in Nebraska have been raped, and 325,000 otherwise sexually victimized, sometime in their lives.[1] An additional 174,000 Nebraska males have experienced sexual violence other than rape in their lifetimes.[2]

The NISVS also reveals that approximately one-third (29.9%) of female victims of rape experience their first rape between 11 and 17 years or age, with 37.4% going on to experience their first rape between the ages of 18 and 24 years (CDC, 2011). Over one-quarter (27.8%) of men experienced their first rape at or before the age of 10. (Due to the small number of men who reported being raped, the CDC was unable to calculate an estimate for any other age categories for male victims.)

Data from the YRBS further support these findings. The YRBS indicates that 11% of female students in grades 9 – 12 and 5% of male students in grades 9 – 12 reported being forced to have sex (Nebraska Department of Education and Nebraska Department of Health and Human Services, 2011). (Please note that the YRBS measures only physical force to have sex, while the NSVIS includes other nonconsensual acts such as when the victim was drug facilitated rapes.)

The impact sexual violence can have on victims' mental health is complex and unique to each individual. However, research suggests that sexual violence carries a potentially significant impact on victims. For example, studies show that sexual violence can increase the risk for victims to experience post-traumatic stress disorder, depression, anxiety, and suicide. People who experience sexual violence are more likely to use and abuse substances than those who have not experienced sexual violence.

[1] These categories are not mutually exclusive and as a result there may be some duplicate counts. Some women may have reported both rape and sexual violence other than rape, which would place them in both categories.
[2] Estimates on the prevalence of rape among Nebraska men could not be made due to the small number of men who reported rape. Such small numbers result in unreliable estimates.

Some unique barriers to sexual violence prevention efforts in Nebraska exist in schools. Not all schools, particularly rural schools, have in-house school nurses, counselors, or resource officers to help facilitate sexual violence prevention. Classroom sizes are increasing, whereas time and resources are decreasing, making it even more difficult to incorporate sexual violence prevention into schools. Administrators indicate semester schedules are perpetually full. This leads to additional time and energy placed into "selling" the need for sexual violence prevention to administrators and teachers in the schools. Certainly these barriers are not totally unique to Nebraska; however said barriers are magnified in rural communities. Communities in which sexual violence is not often discussed and resources are spread thin across large geographic areas. In these areas, targeting schools in prevention efforts is important, as schools are one of the few places in which young people in rural communities can aggregate and discuss sexual violence and prevention.

Target Population:
Number: 175,005
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 85,329
Ethnicity: Hispanic, Non-Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, Native Hawaiian or Other Pacific Islander, White
Age: 12 - 19 years
Gender: Female and Male
Geography: Rural
Primarily Low Income: No
Location: Specific Counties
Target and Disparate Data Sources: U.S Census Data, 2010 Ages 12 to 18; Rural includes all counties, except Douglas, Sarpy and Lancaster

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Other: Foubert JD, Tabachnick J & Schewe PA. (2010). The prevention of sexual violence: A practitioner's sourcebook. Kaufman, K (Ed.). Holyoke, MA: NEARI Press.

Tabachnick, J. (2008). Engaging bystanders in sexual violence prevention. Enola, PA: National Sexual Violence Resource Center.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $37,917
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $20,000

Funds to Local Entities: $36,752
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
10-49% - Partial source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Social marketing components
Between 10/2013 and 09/2014, Nebraska Domestic Violence Sexual Assault Coalition staff will maintain **1** sexual assault primary prevention social marketing campaign.

Annual Activities:
1. Step Up Speak Out Website
Between 10/2013 and 09/2014, Based on the premise that youth utilize social networking sites, the Coalition has created the Step Up Speak Out (SUSO) website to educate youth, parents, teachers, and community members about bystander engagement and healthy relationships.
The Coalition will maintain the website in order to:
- Attract new hits and traffic to the website.
- Provide education about engaging bystanders in sexual violence prevention.
- Include information about the available services at the local programs.

2. Step Up Speak Out Social Media Outreach
Between 10/2013 and 09/2014, to complement the SUSO website, the Coalition will maintain Facebook, Twitter, and YouTube sites to leverage communication about healthy relationships and bystander engagement. The videos from the Youth Video Project will be posted on these sites as well.
Effectiveness of this component is measured by number of site visits and followers.
During the last year, the number of visits to the website was 2,877.

Facebook: 85 likes
Twitter: 65 followers

Goals for next year:
Visitors: 2,000
Facebook: 110 likes
Twitter: 90 followers

3. Increase local programs' capacity to measure effectiveness.
Between 10/2013 and 09/2014, the Coalition will introduce response technology into classrooms to actively engage students and easily assess students' attitudes and knowledge about dating violence and healthy relationships before, during and immediately after educational sessions.

State Program Title: WORKSITE WELLNESS PROGRAM

State Program Strategy:

Program Goal: The PHHS Block Grant-funded ***Worksite Wellness Program*** is dedicated to improving the overall health of Nebraska adults through their places of employment.

Health Priorities: Building capacity among employers to provide data-driven, comprehensive worksite health promotion services statewide, primarily through Nebraska's worksite wellness councils and local health agencies.
Primary Strategic Partners: Local worksite wellness councils (WorkWell, Panhandle Worksite Wellness Council and WELCOM), local health departments and human services agencies, hospitals, state government, local health coalitions, public schools, universities and colleges, Nebraska DHHS Programs, Nebraska Sports Council, employers.
Evaluation Methodology: Tracking changes in health status data: Behavioral Risk Factor Surveillance Survey; LiveWell health assessment survey; reports from participating businesses on changes in health care and insurance costs; aggregate, de-identified biometric data obtained from employees health risk assessments; and the environmental and policy change information from the Nebraska Worksite Wellness Survey; Governor's Award database.

State Program Setting:
Business, corporation or industry, Community based organization, Local health department, Schools or school district, State health department, University or college, Work site

FTEs (Full Time Equivalents):
Full Time Equivalents positions that are funded with PHHS Block Grant funds.

Total Number of Positions Funded: 0
Total FTEs Funded: 0.00

National Health Objective: HO ECBP-8 Worksite Health Promotion Programs

State Health Objective(s):
Between 10/2013 and 09/2018, provide support to three worksite wellness councils in order to build capacity to conduct evidence-based health promotion activities for workers and document improvement in health status of workers.

Baseline:
There are three well-developed Worksite Wellness Councils operating in Nebraska.
PHHSBG subawards have been made to support continued development of worksite wellness councils in Nebraska; the Nebraska Safety Council that operates the WorkWell Council, the Panhandle District Health Department that operates the Panhandle Worksite Wellness Council and Wellness Council of the Midlands (WELCOM).

Data Source:
Nebraska Department of Health and Human Services, WorkWell, Panhandle Council, WELCOM

State Health Problem:

Health Burden:
Only a fraction of Nebraska worksites offer comprehensive health promotion programs to their employees, leaving many opportunities to reach working-age adults with health promotion and prevention messages, as well as services such as health risk appraisal and counseling to lower risk to employee health.

In 2010, the NDHHS conducted a survey among 1,512 businesses in Nebraska to determine the extent of initiation and development of worksite wellness programs across the state. The survey went to small, medium and large scale businesses across all sectors. Results showed:

-- Fewer than 1 in 4 businesses provided incentives to employees or have policies supporting physical activity.
-- 1 in 6 businesses had policies encouraging healthy food at company events.
-- 1 in 4 had smoke-free policies prohibiting smoking on the entire worksite.
-- 1 in 6 had wellness coordinators.
-- 1 in 10 offer health screenings.
-- More than 75% provided health insurance.
-- Cost was a commonly reported barrier to implementing worksite wellness programs.

The cost of chronic disease in Nebraska is considerable.

Hypertension (high blood pressure) cost an estimated $698 million for 2010. That cost is predicted to increase to $1,203 million in 2020.

Stroke cost an estimated $413 million in 2010. That cost is predicted to increase to $731 million by 2020.

Coronary Heart Disease cost an estimated $723 million in 2010. The cost is predicted to increase to $1,279 million by 2020.

The 2010 cost estimate above includes expenditures for office-based visits, home health care, vision aids, other medical supplies and equipment, prescription medicines, and nursing homes. Payer populations are not mutually exclusive. Costs for All Payers are calculated independently of costs for Medicaid, Medicare, and Private Insurers.

The 2020 cost projection above are medical costs only, including nursing home costs, but excluding absenteeism costs.

Target Population:
Number: 120,000
Ethnicity: Hispanic, Non-Hispanic

Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 20 - 24 years, 25 - 34 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No

Disparate Population:
Number: 20,000
Ethnicity: Hispanic
Race: African American or Black, American Indian or Alaskan Native, Asian, White
Age: 20 - 24 years, 25 - 34 years, 35 - 49 years, 50 - 64 years
Gender: Female and Male
Geography: Rural and Urban
Primarily Low Income: No
Location: Entire state
Target and Disparate Data Sources: Department of Economic Development, Worksite Wellness Councils, CDC's Chronic Disease Cost Calculator

Evidence Based Guidelines and Best Practices Followed in Developing Interventions:

Guide to Community Preventive Services (Task Force on Community Preventive Services)

Other: Task Force on Community Preventive Services states the "use of selected worksite policies and programs can reduce health risks and improve the quality of life for 141 million full and part-time workers in the United States." Nine exemplary companies were studied by the national task force. Two of the nine companies, Lincoln Industries and Duncan Aviation, are WorkWell member companies.

Well Workplace Seven Benchmarks for Success from Wellness Council of America (WELCOA), modified to meet local Nebraska needs.

Evidence based worksite health model.

Funds Allocated and Block Grant Role in Addressing this Health Objective:

Total Current Year Funds Allocated to Health Objective: $160,500
Total Prior Year Funds Allocated to Health Objective: $0
Funds Allocated to Disparate Populations: $100,000
Funds to Local Entities: $160,500
Role of Block Grant Dollars: Supplemental Funding
Percent of Block Grant Funds Relative to Other State Health Department Funds for this HO:
50-74% - Significant source of funding

OBJECTIVES – ANNUAL ACTIVITIES

Allocated funds are used to achieve Impact & Process Objective outcomes and to carry out Annual Activities that are based on Evidence Based Guidelines and Best Practices identified in this work plan.

Objective 1:
Evidence Based Interventions
Between 10/2014 and 09/2015, NDHHS staff, WELCOM, WorkWell, and Panhandle Worksite Wellness Council will increase the number of employers who are impacting employees through evidence-based interventions specific to active living, healthy eating, and breastfeeding strategies from 10 to **20**.

Annual Activities:
1. Physical Activity Worksite Interventions
Between 10/2014 and 09/2015, The Nebraska Walking Worksite Initiative is an outreach effort in partnerships with the three Worksite Wellness Councils (WorkWell, WELCOM, and Panhandle Worksite

Wellness Council) to implement sustainability strategies for physical activity access projects within worksites. The Initiative first trains Worksite Councils, businesses and communities on how to begin, plan, assess, implement and evaluate a comprehensive walking initiative. Emphasis is placed on strategies to improve access through environmental strategies such as point of decision prompts, policy strategies for flex time physical activity, fitness reimbursement, break time policies, and social support strategies like wellness team and walking club opportunities.

2. Healthy Eating Interventions
Between 10/2014 and 09/2015, DHHS staff will be working in partnership with the three worksite wellness councils to provide direct training, technical assistance, and support to member businesses to implement healthy eating policy, systems and environmental change strategies based on employer's needs. Strategies include developing, enhancing, and implementing policies and practices supportive of healthy eating across workplace venues (i.e. vending, meetings, on-site cafeteria, events.)

3. Breastfeeding Interventions
Between 10/2014 and 09/2015, DHHS staff will be working in partnership with the three worksite wellness councils and ELITE Lactation Services to provide direct training, technical assistance, and support to member businesses to implement breastfeeding policy, systems and environmental change strategies based on the employers needs. Strategies include developing, enhancing, and implementing breastfeeding worksite policies and practices supportive of breastfeeding employees.

Objective 2:
Worksite Wellness Capacity
Between 10/2014 and 09/2015, NDHHS staff and subawardees and contractors will provide technical assistance designed encourage active engagement in worksite health promotion activities to **150** worksites.

Annual Activities:
1. Training and Technical Assistance
Between 10/2014 and 09/2015, provide technical assistance and training to at least 145 worksites.

The worksite wellness councils partially supported by the PHHSBG distribute newsletters, and provide training seminars, peer learning/idea sharing, assistance with preparing to meet the qualifications for the Governor's Wellness Award, and phone counseling,

2. Training and Technical Assistance for Evidence-Based Interventions
Between 10/2014 and 09/2015, DHHS staff will help to build the capacity of the three Worksite Wellness Councils to implement and provide technical assistance for employers specific to evidence-based interventions for active living, healthy eating and breastfeeding. Trainings will be provided on the implementation of the CDC Worksite Physical Activity Toolkit, the Nebraska Walking Worksite Initiative, the Nebraska Healthy Beverage Guide, healthy meetings and strategies for implementing workplace lactation programs.